

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 8501

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JAMES

HURTT

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1967 6:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

908 N. Gay St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

908 N. Gay St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 27, 1919

9. AGE (In years
lost birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Hurtt

14. MOTHER'S MAIDEN NAME

Nettie Cole

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Theodore Hurtt

ADDRESS

2239 Orleans St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-Cerebral Injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

908 N. Gay St. Rear

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

UNK

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-9-1967

23C. NAME of CEMETERY or CREMATORY

MT. CALvary Cem.

23D. LOCATION

(City, town, or county)

Brooklyn

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

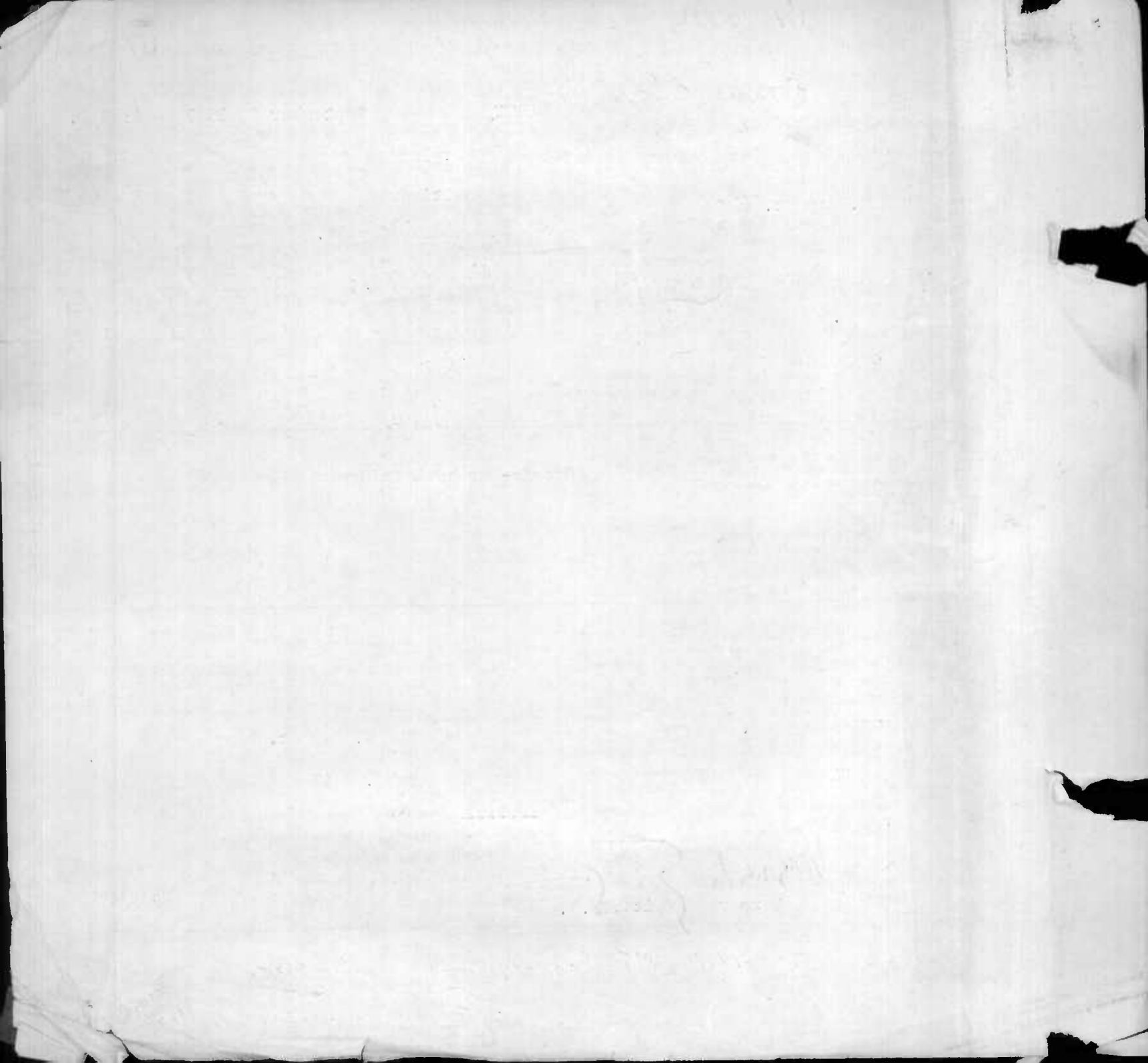
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 6 1967

Elroy O. Wilson 1000 Broadway Ave



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8503

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DANIEL

SHORT

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1967

12:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3420 St. Ambrose Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Nov. 25-1905

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel C. Short sr.

14. MOTHER'S MAIDEN NAME

Lillie Mae

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic and Hypertensive
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-11-67

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION (City, town, or county)

Arbutus

(State)

md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 6 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Erroy O. Wilson

ADDRESS

1000 Brimley Ave.

C-462

67 8504 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 8504

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HAROLD

CLARK

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1967

5:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1240 E. Monument Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1240 E. Monument Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

March 25 - 1900

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, MD

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Clark

14. MOTHER'S MAIDEN NAME

Rosa Snowden

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Samuel Clark

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK

NOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/67

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-8-67

23C. NAME of CEMETERY or CREMATORY

Int. Calvary Cal

23D. LOCATION (City, town, or county)

Brooklyn

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 6 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Elroy Wilson 1000 Brantley

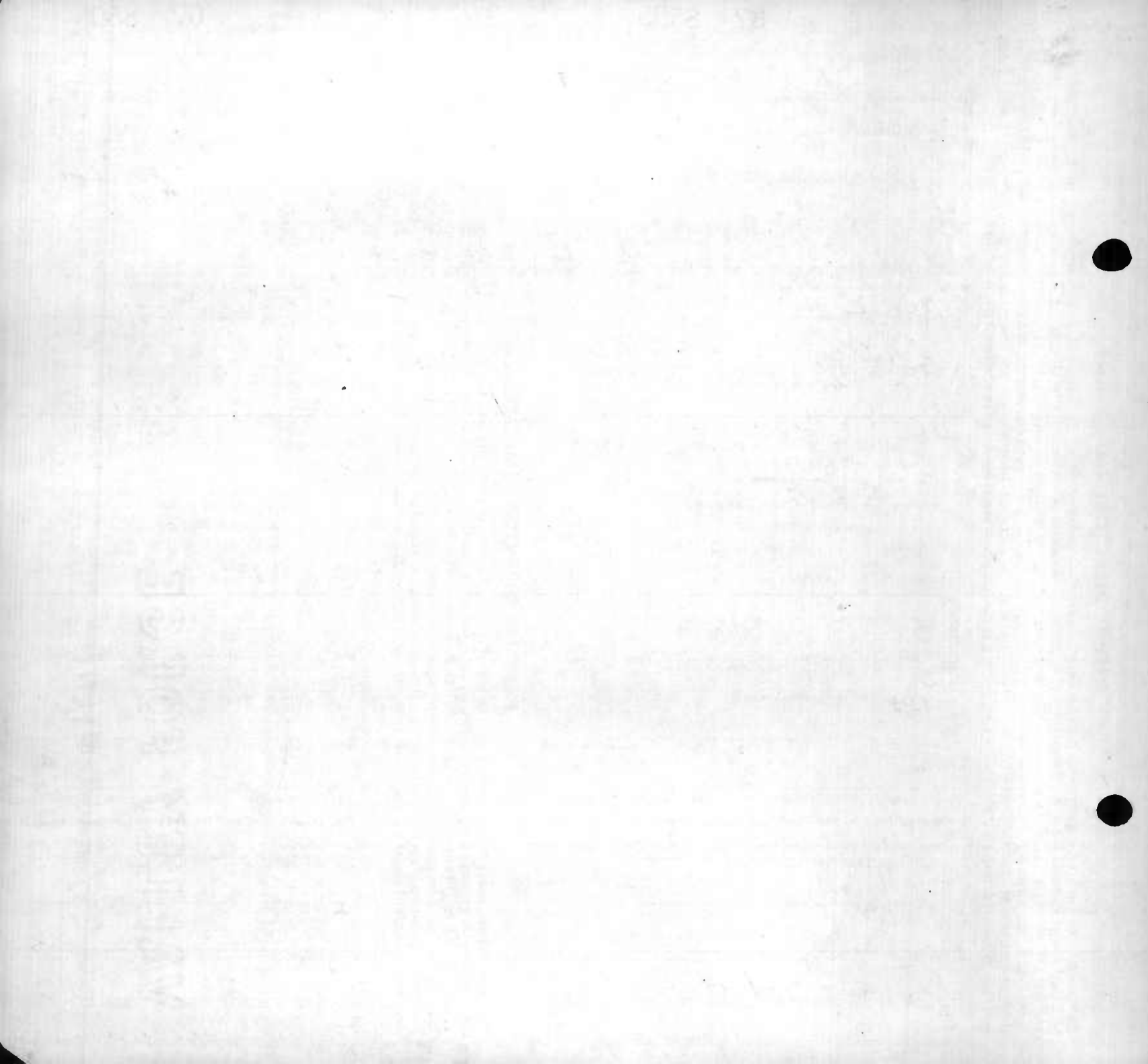
ADDRESS

WALLACE & GORDON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8505	
BIRTH NO. 67 8505		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAGGIE J. MAJETT		2. DATE AND HOUR OF DEATH 8-30-67 2 52 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp of Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 15-37			
5. SEX F		6. RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Henry J. Jaylor		14. MOTHER'S MAIDEN NAME Elizabeth Ash		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Katherine Barnes ADDRESS 2724 Langwood St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Auto Myocardial Infarction		CAUSE OF DEATH (A) DUE TO Auto Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH LT Hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Coronary Artery Thrombosis		LT Hr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Arteriosclerotic Hypertensive ? C-V Disease			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 8-30-67 19 19 to 8-30 19 67 , that (X) (we) last saw the deceased alive on 8-30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. J. Dureza		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-30-67	
23C. PHYSICIAN'S NAME (Type) R. J. Dureza		23D. ADDRESS c/o Lutheran Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 9-1-67		24C. NAME OF CEMETERY or CREMATORY Private Cemetery Rich Square N.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1967		25B. NAME OF REGISTRAR R. E. Farkner		25C. FUNERAL DIRECTOR Arlington S. Phillips ADDRESS 1727 N. Mount	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8506

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
LEONARD

ROGERS

2. DATE AND HOUR PRONOUNCED DEAD

August 26, 1967 7:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL OR ADDRESS OR LOCATION)
INSTITUTION

Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1627 Milliman Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

June 6, 1914

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Edena Saunders 1627 Milliman St

18. E981X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive Internal Bleeding
DUE TO gunshot wound of abdomen involving
Mesentery and small intestine.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Bar

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

702 N. Caroline St. - Silver Bar

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8/26/67

7:20 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. shot in bar

10-02

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/26/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-2-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 6 1967

A. B. E. Johnson

Arlington S. Phillips

1727 N. Howard St.

WALLACE PAPER

2 1/2 IN. CIRCUM

49-87-76 IB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-87-76 IB		BIRTH NO. R-352		67 8507		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 8507	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Redding, Elsie				2. DATE AND HOUR OF DEATH 9/6/67 12:40 AM M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. DATE AND HOUR OF DEATH					
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS		(If not in hospital or institution, give street address or location) 4940 EASTERN AVENUE				A. STATE Maryland		B. COUNTY Charles			
6. CITY OR TOWN (If outside city limits, write RURAL and give township)		7. STREET ADDRESS (If rural, give location)				C. CITY OR TOWN La Plata		D. STREET ADDRESS Box 68			
15. SEX F		16. RACE W		17. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		18. DATE OF BIRTH 11-15-19		19. AGE (in years last birthday) 47		20. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME -		14. MOTHER'S MAIDEN NAME -	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 229-18-4868		17. INFORMANT RECORDS - BCH - 4940 EASTERN AVENUE		ADDRESS RECORDS - BCH - 4940 EASTERN AVENUE		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Renal Failure		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Sepsis		20. (A) DUE TO Chemia		21. (B) DUE TO Chemia		22. (C) DUE TO Chemia		23. INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetic Mellitus, Pneumonia		24. DATE OF OPERATION 8/10/67		25. CONDITION FOR WHICH OPERATION WAS PERFORMED Purulent sinus - Debrided		26. AUTOPSY? (Yes or No) Yes		27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 3		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -		21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (1) (this hospital) attended the deceased from 9/1 1967 to 9/6 1967 , that (1) (we) last saw the deceased alive on 9/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE Benjamin D. Richman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/6/67		23C. PHYSICIAN'S NAME (Type) Benjamin D. Richman		23D. ADDRESS BCH - 4940 EASTERN AVENUE, BALTIMORE, MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-8-67		24C. NAME OF CEMETERY or CREMATORY Sunset		24D. LOCATION (City, town, or county) (State) Spotsylvania Co.		25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR R. T. Pinner	
25C. FUNERAL DIRECTOR R. T. Pinner		ADDRESS 7000		25D. NAME OF REGISTRAR R. T. Pinner		25E. FUNERAL DIRECTOR R. T. Pinner		25F. ADDRESS 7000		25G. NAME OF REGISTRAR R. T. Pinner	

G-435

67 8508 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8508

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SARAH GOLDINGER

2. DATE AND HOUR PRONOUNCED DEAD

September 2, 1967 10:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

207 W. Franklin Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

207 W. Franklin Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Unknown

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Morris Goldinger

14. MOTHER'S MAIDEN NAME

Ethel (last name unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
213-34-3053

17. INFORMANT

2336 N. 11th Street,
Leonard Goldinger Arlington, Va.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Hypertensive and arteriosclerotic
cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept. 5, 1967

23C. NAME of CEMETERY or CREMATORY

National Capital Hebrew

23D. LOCATION

(City, town, or county)

Hillside, Maryland.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1967

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

Donald M. Stein Hebrew 232 Carroll St., N. W.
Memorial Funeral Home Washington, D. C.

ADDRESS

MAIL LITV FORGE
DISCARD CARTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8509	
BIRTH NO. 67 8509		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) COLLINS MRS. GERTRUDE		2. DATE AND HOUR OF DEATH SEPT 3rd 1967 8.00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL 100 N. BROADWAY, BALTO., MD. 31		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Dundalk 53-00		D. STREET ADDRESS (If rural, give location) 2421 MEADOW RD.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-4-1889	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME Casimir DONNICK		14. MOTHER'S MAIDEN NAME Magdalene ECKLE LITIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219 058566		17. INFORMANT 4209 Frappe Rd. Son-in-law, Edward L. Jaworski, Dundalk, Md. 21222	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Cerebral Thrombosis (C) 2 wks (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardiovascular Disease & atrial Fibrillation yes		INTERVAL BETWEEN ONSET AND DEATH 21222			
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from Aug 17 1967 to Sept 3 1967 that (I) (we) lost saw the deceased alive on Sept 3, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. G. Baltazar, Jr. M.D.		23B. DATE SIGNED Sept 3, 1967			
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR, JR.		23D. ADDRESS CHURCH HOME & HOSP. 100 N. BROADWAY			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/7/67		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR P. E. Taylor	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25D. ADDRESS			

A 1000 A

RECEIVED

DAY WORK -

24 21 MEADOW RD

12-7-1933 11

RECEIVED

11-12-1933

RECEIVED - WHITE

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

1
R-200

67 8510 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8510

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

J.

RICE

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1967

12:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

548 Yale Avenue

25-31

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12-14-1944

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Fabricator

10B. KIND OF BUSINESS OR INDUSTRY

Md. Drydock

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William C. Rice

14. MOTHER'S MAIDEN NAME

Caroline J. Hoernlein

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
214-44-1509

17. INFORMANT

ADDRESS

Mrs. Phyllis E. Rice, 548 Yale Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Patapsco Avenue - 336 Ft. East

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9/4/67

(Month) (Day) (Year) (Hour)

12:05A.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. driver of auto

struck telephone pole

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

9/4/67

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-8-1967

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

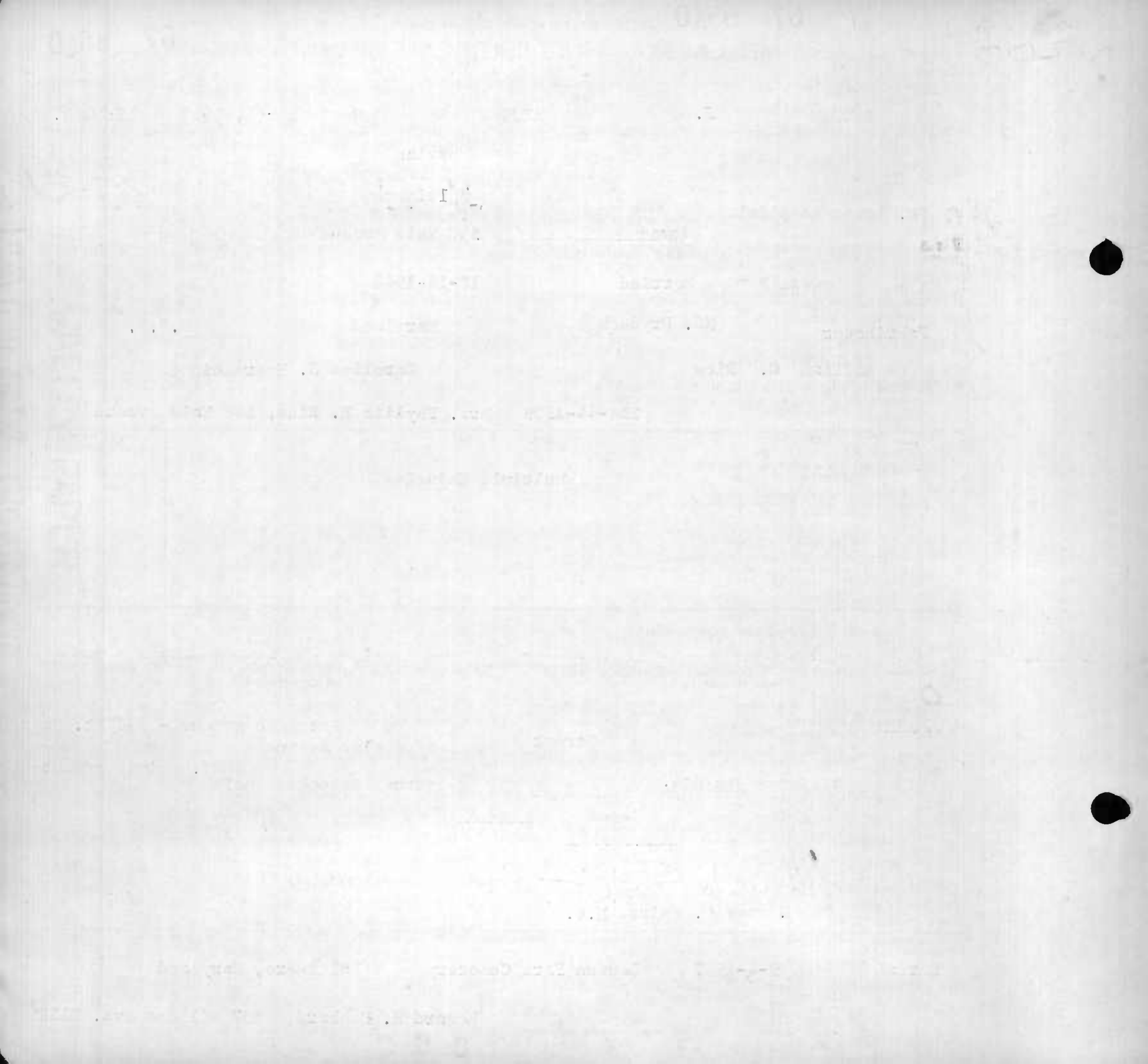
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 7 1967 Robert E. Fisher, M.D.

Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8511				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8511	
1. NAME OF DECEASED (Type or Print) MINNIE A METZ				2. DATE AND HOUR OF DEATH 9 2 67 5:55 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE XXX 21229 Halethorpe 53-00 D. STREET ADDRESS (If rural, give location) 5707 SECOND AVENUE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10 30 89	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET PITTSBURG P G		10B. KIND OF BUSINESS OR INDUSTRY PITTSBURG P G		11. BIRTHPLACE (State or foreign country) MARYLAND, BALTO.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME CHARLES FAIR FALK,			14. MOTHER'S MAIDEN NAME POETZEL, ANNIE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-05-2900B		17. INFORMANT ADDRESS ST AGNES RECORDS WILKENS & CATON AVES.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 450.0 CAUSE OF DEATH Generalized arteriosclerosis Chronic pyelonephritis				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 7 26 1967 to 9 2 1967 , that (1)(we) lost saw the deceased alive on 9 2 1967 and that in (1)(y) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Korbuly				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/3/67	
23C. PHYSICIAN'S NAME (Type) S. KORBULY				23D. ADDRESS 21229 ST. AGNES HOSP. CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-6-1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

2:22

2

WHITE A. HETT

INVESTIGATION

2777 SECOND AVENUE
ALTOONA, PA.

ST AGNES HOSPITAL

10 20 22

MARRIED

F W

U S A

NEWYARD

PITTSBURG

RET PITTSBURG

POSTEL

CHARLES PARK

ST AGNES RECORDS WILKINS & CATON AVES.

NO

27

X

X

X

X

X

X

2111

X

ST AGNES HOSP. CATON & WILKINS AVES.

2-1-1927

2-1-1927

2-1-1927

2-1-1927

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8512
BIRTH NO. 67 8512		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED CHRIST, MARGARET A.		2. DATE AND HOUR OF DEATH SEPTEMBER 3, 1967 9:30AM M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BaltoC C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21207 D. STREET ADDRESS (If rural, give location) 5521 FOREST PARK AVE.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 11-10-94	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME HENRY RICHTER		14. MOTHER'S MAIDEN NAME ADELINE (XX) Sterke		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 05 4025	17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVE	
18. 230X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Intestinal obstruction - small one day by DUE TO (B) bowel perforation & peritonitis history. DUE TO (C) Tumor of bowel.		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 9-3-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis & obstruction	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that X (this hospital) attended the deceased from SEPTEMBER 3 19 67 to SEPTEMBER 3 19 67 , that X (we) last saw the deceased alive on SEPTEMBER 3 19 67 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXXX view the body after death.				
23A. SIGNATURE C. H. Matthey		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 09-03-67
23C. PHYSICIAN'S NAME (Type) C. H. MATTHEY,		23D. ADDRESS CATON & WILKENS AVES.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-6-1967	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Farkner	25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

SEP 11 1967

CHIEF, PHOTOCOPY

RECEIVED

ST. AGNES HOSPITAL

CATON & WILKINS
BALTIMORE, MD. 21222

5521 FOREST PARK AVE.

11-10-67

FEMALE WHITE WIDOWED

U.S.

WITLAND

HOUSEWIFE

ADELINE (1)

HENRY RICHTER

212 DE HOSS ST. AGNES RECORDS-CATON & WILKINS

RD

Handwritten notes:
Adeline Richter
Caton & Wilkins
Baltimore, Md.

Handwritten: 1-2-68

SEPTEMBER 3

XX

SEPTEMBER 3

SEPTEMBER 3

XX

09-03-67

CATON & WILKINS AVE.

Handwritten: C. H. MATTHEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 8513					67 8513					
BIRTH NO.					Registered No.					
M.E. CASE NO.					X					
1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH					
(Type or Print) ALBIKER, Harry Earl					9-3-67 5:55 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 27 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218					A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto Co. CATONSVILLE D. STREET ADDRESS (If rural, give location) 53-00 239 GRALAN ROAD					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		
MALE		CAUCASION		MARRIED		8-15-10 -1910		57		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
CHAUFFEUR			SELF EMPLOYED			BALTIMORE, MARYLAND		U. S. A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
HARRY A. ALBIKER					MARY CHRISTOPH Christoph					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES					10-20-43 TO 11-16-45		213-01-2237		VA HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTIMORE, MD.	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA					2 HOURS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PULMONARY CUTANEOUS FISTULA					CARCINOMA RIGHT LUNG					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					ARTERIOSCLEROSIS					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2			Carcinoma Lung			YES				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>				
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that he (this hospital) attended the deceased from 7-18-67 19 67 to 9-3 19 67 , that he (we) last saw the deceased alive on 9-3 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, 20 (We) (did) not view the body after death.										
23A. SIGNATURE						23B. DATE SIGNED				
Edward O. Hunt M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						9/4/67				
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS				
EDWARD O. HUNT, M.D.						3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial			9-7-1967		Baltimore National Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
SEP 7 1967			Robert E. Taylor, Jr.			Howard H. Hubbard, 4107 Wilkens Avenue				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8514					67 8514				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
WURMSER, LEO					9-4-67 8:00 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
ST AGNES HOSPITAL					MARYLAND				
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
MALE WHITE MARRIED					BALTO.				
8. DATE OF BIRTH 9. AGE (In years lost birthday)					D. STREET ADDRESS (If rural, give location)				
2-5-05 62					4531 RIDGE DRIVE 21229				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
VICE PRESIDENT					CONRAD PROTZMAN				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
GERMANY					U.S. A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
LOUIS Wurmser					ANNA NIEDERBUCHNER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
NO					215-09-8580				
17. INFORMANT ADDRESS					18. CAUSE OF DEATH				
ST AGNES HOSPITAL RECORDS, 1000 S CATON AVE., BALTO., MD. 21229					DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				
INTERVAL BETWEEN ONSET AND DEATH					(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
420.11					ACUTE CORONARY THROMBOSIS				
ANTECEDENT CAUSES					DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
0					NO				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
NO					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?				
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					22. I certify that (I) (this hospital) attended the deceased from 8/28 19 67 to 9/4/ 19 67, that (I) (we) last saw the deceased alive on 9/4/ 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE					23B. DATE SIGNED				
S. Korbuly					9-4-67				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
SUSANNA KORBULY, M.D.					ST AGNES HOSPITAL, 1000 S CATON AVE. BALTO., MD. 21229				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Burial					9-7-1967				
24C. NAME OF CEMETERY OR CREMATORY					24D. LOCATION (City, town, or county) (State)				
Lorraine Park Cemetery					Baltimore County, Maryland				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
25C. FUNERAL DIRECTOR ADDRESS					25D. ADDRESS				
SEP 7 1967					Howard H. Hubbard, 4107 Wilkens Ave. 21229				

WURNER, LEO

8:00

WALLAND

DALTON

WEST RIDGE DRIVE 21229

ST AGNES HOSPITAL

MALE WHITE MARRIED

2-2-02

62

VICE PRESIDENT CONRAD PROTHMAN GERMANY

U.S.A.

ANNA HEDERBUCHNER

LOUIS

NO

ST AGNES HOSPITAL RECORDS, 1000 S CATON AVE., BALTO., MD. 21229

NO

8128 67

9141 67

9141

9-4-67 X

ST AGNES HOSPITAL, 1000 S CATON AVE. BALTO., MD. 21229

SUSANNA KORBULY, M.D.

10-1-67

10-1-67

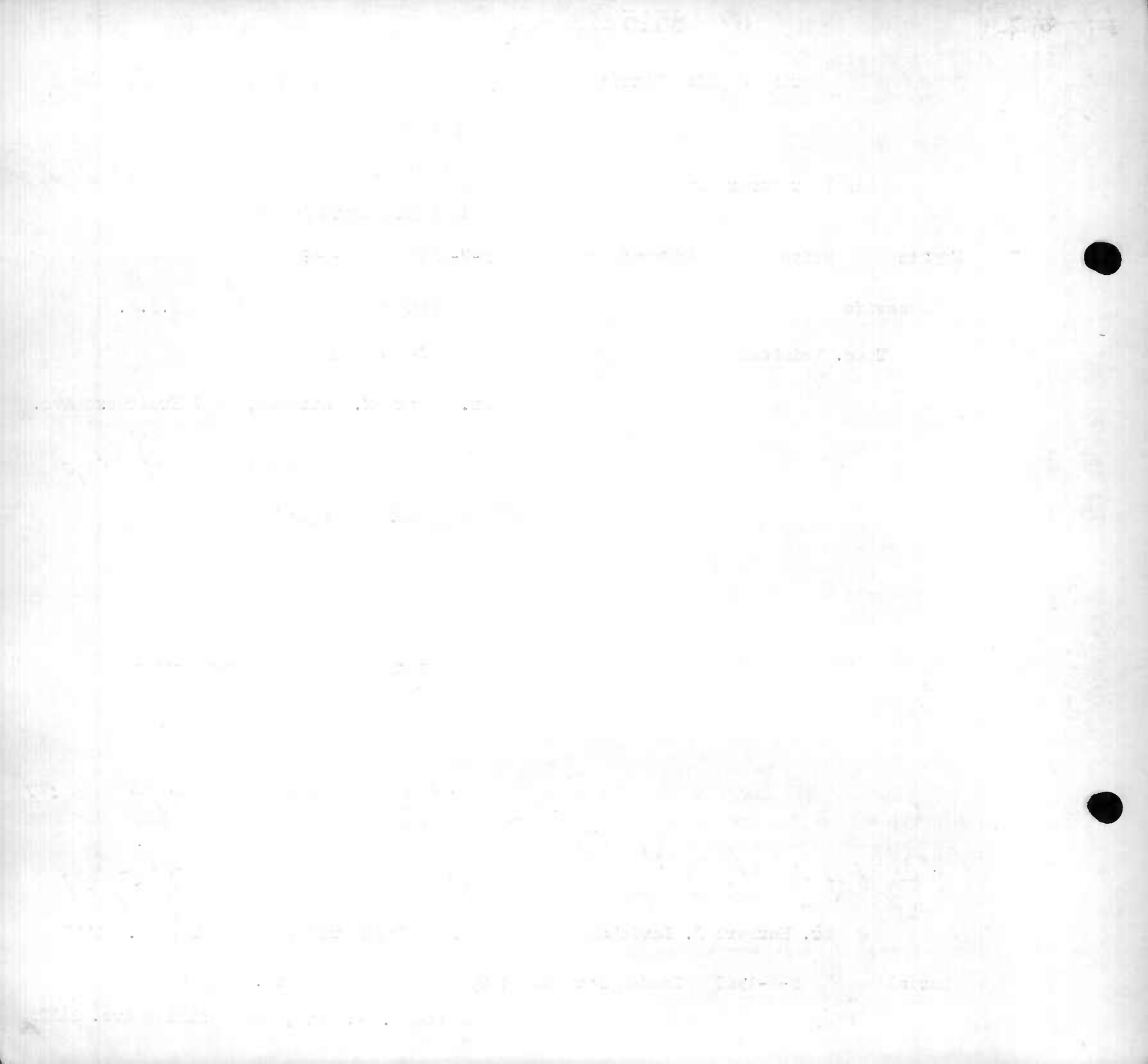
10-1-67

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8515				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8515	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Maria Sophia Harrison				September 4, 1967 11:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
1907 Breitwert Avenue				Maryland			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Female		White		Widowed			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife						Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Theo. Leimbach				Julia Ann			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Mr. Edward T. Harrison, 1907 Breitwert Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) Central thrombosis		4 days	
ANTECEDENT CAUSES				(B) Arteriosclerotic CVD			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/1 1967 to 9/4 1967, that (I) (we) last saw the deceased alive on 9/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Herbert J. Levickas				9/5/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Herbert J. Levickas				5404 East Drive, Baltimore, Md. 21227			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-6-1967		Loudon Park Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 7 1967		Robert E. Hubbard		Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 8516	
BIRTH NO. 67 8516				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) FOWLER Edward W. WM.				2. DATE AND HOUR OF DEATH SEPTEMBER 3 1967 11:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON & WILKENS AVENUE BALTO 21229 MD				A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 21227 MD			
D. STREET ADDRESS (If rural, give location) 5233 DE WITT RD				53-00			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 08/24/98		9. AGE (In years) 69 YRS	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-B&O RAILRO		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY Fowler				14. MOTHER'S MAIDEN NAME WILLIAMS Sadie Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 705-05-3351		17. INFORMANT ADMISSION SLIP		ADDRESS (ST AGNES HOSP.)	
18. CAUSE OF DEATH 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) CARCINOMA OF THE LUNG. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 YEARS?	
(B) CHRONIC EMPHYSEMA DUE TO				(C) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 8/23/67 to 9/3/67 , that (X) (we) last saw the deceased alive on SEPT. 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Rodolfo Revilla</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/3/67	
23C. PHYSICIAN'S NAME (Type) RODOLFO REVILLA				23D. ADDRESS M.D. ST AGNES HOSPITAL, 1000 S CATON AVE., BALTO. MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. SEPT 7 1967		25B. NAME OF REGISTRAR <i>Robert E. Hubbard</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

ST AGNES HOSPITAL
CATON & WILKINS AVENUE
BALTO 21229 MD

MALE WHITE MARRIED

RETIRED-B&O RAILROAD

HARRY SWANER

UNKNOWN

702-02-3321

UNCLASSIFIED

BALTO. MD. U.S.A.

DOB 12/27/98 1 28 YRS

1222 DE WITT RD

ST AGNES HOSPITAL

BALTIMORE COUNTY

ROWLER, Wm.

SEPTEMBER 2 1967 11:30 P

RODOLFO REVILLA

ST AGNES HOSPITAL, 1000 E CATON AVE.,
BALTO, MD. 21229

SEPT. 2

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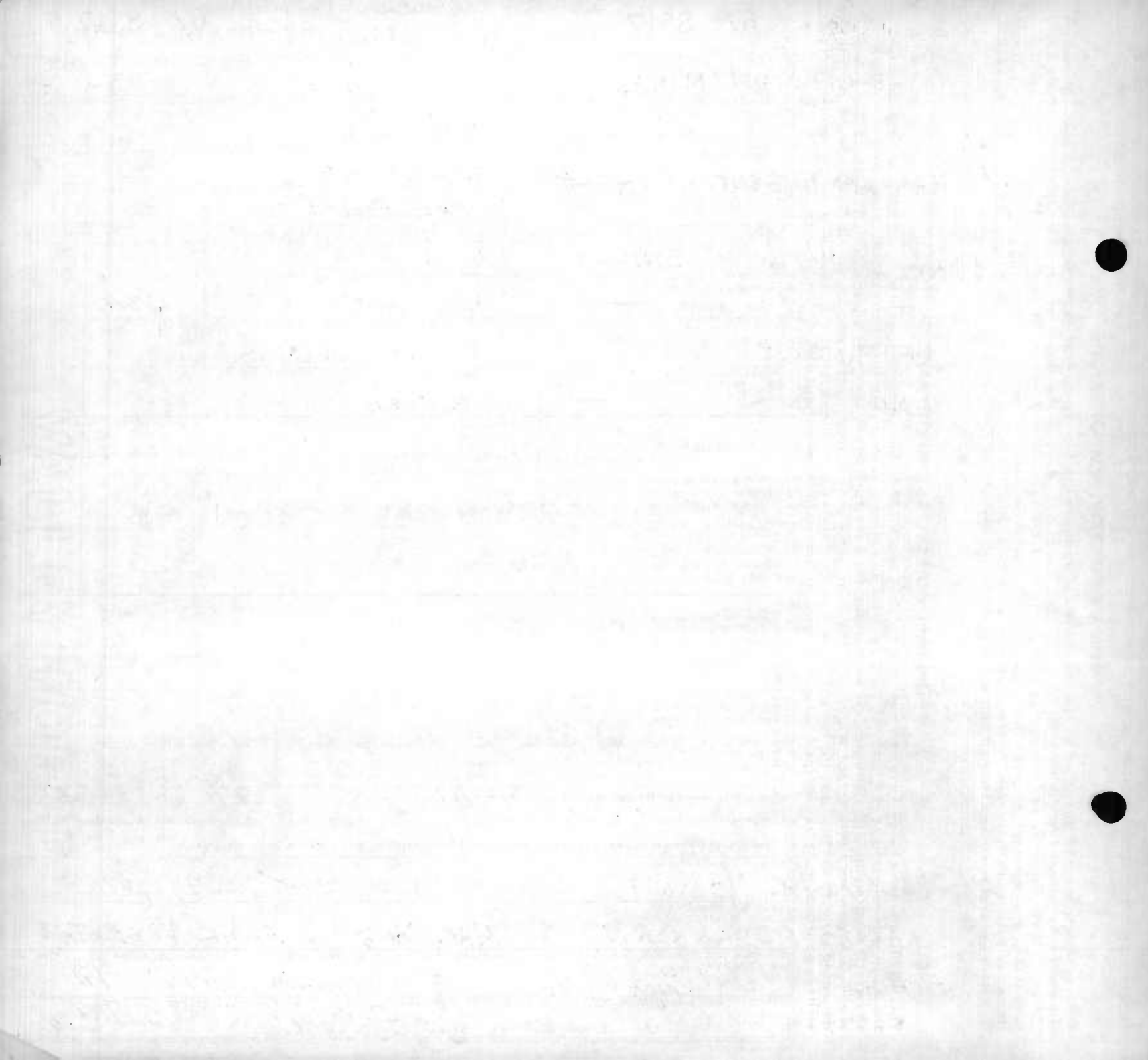
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-16853		67 8517		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8517	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) (BABY) MARY MINAS				2. DATE AND HOUR OF DEATH 9/1/67 4:36 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP				A. STATE B. COUNTY MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 704 S. PONCA ST			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8/19/67	9. AGE (In years last birthday) 12	If Under 1 Yr. Months	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NOT KNOWN				14. MOTHER'S MAIDEN NAME ESTER MINAS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT MOTHER		ADDRESS	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) ASPIRATION				48 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) ABDOMINAL DISTENTION				48 hours			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PREMATURITY							
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/22/67 19 to 9/1 1967, that (I) (we) last saw the deceased alive on 9/1/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles M. Harrison				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/1/67	
23C. PHYSICIAN'S NAME (Type) CHARLES M. HARRISON				23D. ADDRESS MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/2/67		24C. NAME OF CEMETERY or CREMATORY Green Path Cemetery		24D. LOCATION (City, town, or County) (State) Windsor Mill Rd. 10	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR The E. Fisher		ADDRESS 1430 East Bay	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8518		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8518	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LAWRENCE E. MYERS		2. DATE AND HOUR OF DEATH 9/4/67 11:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA C. CITY OR TOWN (If outside city limits, write RURAL and give township) HANOVER D. STREET ADDRESS (If rural, give location) 283 THIRD STREET 17331			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 4-24-27	9. AGE (In years lost birthday) 40	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personnel Clerk		10B. KIND OF BUSINESS OR INDUSTRY Cement Plant		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES MYERS		14. MOTHER'S MAIDEN NAME ELVA HESSON.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-28-45-11-16-1946		16. SOCIAL SECURITY NO. 179-20-6936		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224, MD.	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 190.9 I Malignant melanoma		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/1/67 19 67 to 9/4 19 67 , that (I) (we) last saw the deceased alive on 9/4 19 67 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Phillip L. Hall		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/4/67	
23C. PHYSICIAN'S NAME (Type) DR. PHILLIP L. HALL		23D. ADDRESS BALTIMORE 21224, MARYLAND BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/7/1967	24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Hanover, York CO Pa.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Tepton-Eline - Hampstead, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8519</u>	
BIRTH NO. <u>67 8519</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>Caroline W. Disney</u>		<u>Sept. 4, 1967</u> <u>130</u> A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 House of The Pines Belair Road</u>			A. STATE <u>Md.</u>		
			B. COUNTY <u>Baltimore</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>20-03</u>		
			D. STREET ADDRESS (If rural, give location) <u>1928 McHenry Street</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>July 4, 1873</u>	9. AGE (In years last birthday) <u>94</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jacob Albrecht</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Strin</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-52-1348</u>	17. INFORMANT ADDRESS <u>Christopher Disney 3514 Sussex Rd</u>		
18. <u>334X I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <u>Cerebral Arteriosclerosis</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 29</u> 19 <u>62</u> to <u>Sept 4</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 4</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E Alessi</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9/5/67</u>
23C. PHYSICIAN'S NAME (Type) <u>Edward J. Alessi</u>			23D. ADDRESS <u>6217m Harford Rd.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9-7-67</u>	24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore City Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, MA</u>		25C. FUNERAL DIRECTOR ADDRESS <u>C. F. EVANS & SON 8802 Harford Road</u>	

July 1943

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8520	
BIRTH NO. 67 8520				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ARTHUR MILTON CAYCE SR			2. DATE AND HOUR OF DEATH 9/5/67 2⁰⁰ A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			A. STATE MD. B. COUNTY Baltimore Co		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3214 E. Joppa Road		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 9-29-96		9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY T.V. Repair Shop	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME Charles Cayce			14. MOTHER'S MAIDEN NAME Jessie Vetenberg		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 217-07-2451	17. INFORMANT Walter L. Cayce		ADDRESS Same
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of large bowel			CAUSE OF DEATH (A) Carcinoma of large bowel DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) with Arteriosclerosis and DUE TO		
			(C) obstruction		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Vascular - Heart disease					
19A. DATE OF OPERATION 8/26/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Relieve of obstruction		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 8/1/67 to 9/5/67 that (I) (we) last saw the deceased alive on 9/5/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE PH. H. DIZGAY				23B. DATE SIGNED 9/5/67	
23C. PHYSICIAN'S NAME (Type) NOUBAR HADJIDIZIAN				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-9-1967		24C. NAME OF CEMETERY OR CREMATORY Pine Grove E.U.B. Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co MD					
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR G. F. EVANS	
				ADDRESS 8802 Hartford Rd	

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Bellevue

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not with Howard

3214 E 20th Road
9-28-90

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8521

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN RENE

2. DATE AND HOUR PRONOUNCED DEAD

September 2, 1967

8:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44
99 Union Memorial Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2858 Harford Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

2/18/13

9. AGE (In years
last birthday)

53

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PAINTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no unknown). (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

219-01-4990

17. INFORMANT

ADDRESS

JOHN RENE TR. 2421 RERRINGMAN RD

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

September 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/7/67

23C. NAME of CEMETERY or CREMATORY

NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Paul C. Charnick

ADDRESS

3617 Chestnut Ave.

E-350

67 8522 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8522

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH E. EATON

2. DATE AND HOUR PRONOUNCED DEAD

September 2, 1967 2:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

210 West 25th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

OCT. 13, 1900

9. AGE (in years
lost birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

CHARLES EATON 5442 MONTDELL AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 2, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/6/67

23C. NAME of CEMETERY or CREMATORY

WOODLAWN

23D. LOCATION

(City, town, or county)

(State)

BALTO. M.D.

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Paul T. Cloninger, Jr.

ADDRESS

361 Chestnut Ave.

WILLIAM LORRAINE

WILLIAM LORRAINE

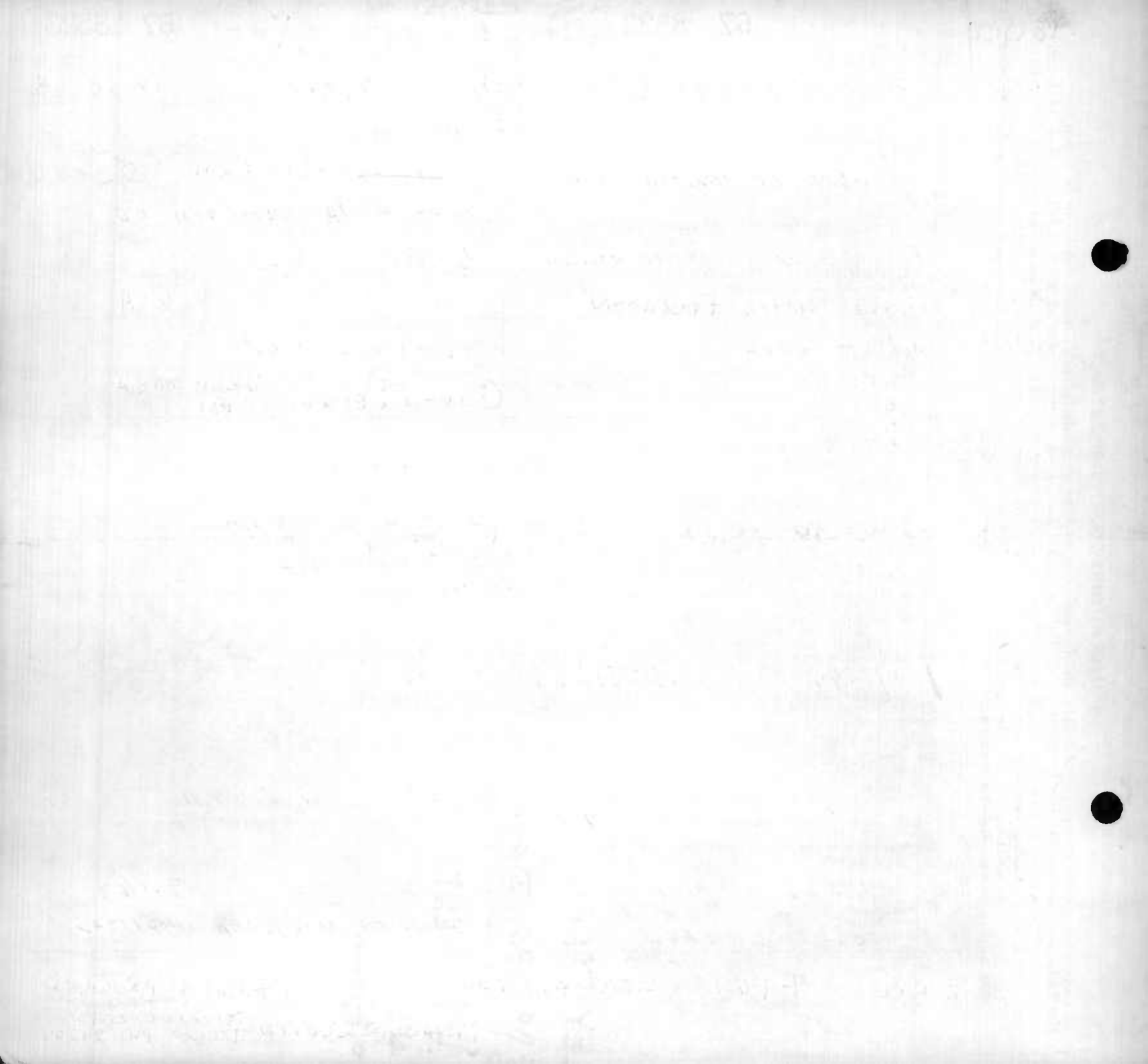
WILLIAM LORRAINE

WILLIAM LORRAINE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
Registered No. 67 8523											
BIRTH NO. 67 8523											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) SISTER MARY EMEDIA (ELLA GROH)											
2. DATE AND HOUR OF DEATH 9/1/67 18:50 A.M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND											
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
A. STATE MARYLAND B. COUNTY Balt Co											
C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN ARM											
D. STREET ADDRESS (If rural, give location) VILLA MARIA, GLEN ARM, MD											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIV. OF MARYLAND HOSP.											
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED											
8. DATE OF BIRTH 1/15/05 9. AGE (in years last birthday) 62											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CATHOLIC SISTER 10B. KIND OF BUSINESS OR INDUSTRY EDUCATION											
11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME AUGUST GROH 14. MOTHER'S MAIDEN NAME ELIZABETH HIOU											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS VILLA MARIA, GLEN ARM, MD											
18. 1931.0 I CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 8/29/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RIGHT FRONTO-PARIETAL GLIOMA 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from 8/25 1967 to 9/1 1967, that (I) (we) lost saw the deceased alive on 9/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Ronald L. Paul M.D. 23B. DATE SIGNED 9/1/67											
23C. PHYSICIAN'S NAME (Type) RONALD L. PAUL M.D. 23D. ADDRESS UNIV. OF MARYLAND HOSPITAL											
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 9-1-67 24C. NAME OF CEMETERY OR CREMATORY SISTERS CEMETERY 24D. LOCATION (City, town, or county) (State) GLEN ARM, MARYLAND											
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967 25B. NAME OF REGISTRAR Robert E. Taylor 25C. FUNERAL DIRECTOR ADDRESS RAYMOND CURRAN, 817 S. CARLETON, TOWSON, MD. 21204											



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67 8524		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8524	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CAROLINE CHRISTINE ARMBROSTER		2. DATE AND HOUR OF DEATH 9:00 PM 9-5-1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP. 44		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13 26-03 D. STREET ADDRESS (If rural, give location) 3331 KENTUCKY AVE		5. SEX F	
6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8-4-77	
9. AGE (In years lost birthday) 90		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Philadelphia PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME PHILLIP APP	
14. MOTHER'S MAIDEN NAME LOUISA LEVEILLE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-46-9476	
17. INFORMANT daughter MRS LOUISA A MILLER		ADDRESS SAME AS D.		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 422.1 + IE 903.7 ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. FRACTURE OF RIGHT FEMUR	
19A. DATE OF OPERATION 21 Aug 67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx of R hip		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 10 1967 3:40 PM		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? THE PINES NURSING HOME 5440 BELAIR RD	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL AFTER GETTING OUT OF CHAIR		22. I certify that (I) (this hospital) attended the deceased from 14 Aug 1967 to 5 Sept 1967, that (I) (we) last saw the deceased alive on 8:30 PM 5 Sept 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE D H Brancato		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5 Sept 1967	
23C. PHYSICIAN'S NAME (Type) DONALD H. BRANCATO D. H. BRANCATO		23D. ADDRESS THE UNION MEMORIAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 9/8/67		24C. NAME of CEMETERY or CREMATORY Fernwood Cemetery		24D. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	

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THE U. S. DEPT. OF AGRICULTURE

REPORT OF THE

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J-623

67 8525 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 8525

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ADAM

FREDERICK

JERSCHIED

2. DATE AND HOUR PRONOUNCED DEAD

September 3, 1967

3:18 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

101 N. Bradford (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

101 N. Bradford

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

5/12/06

9. AGE (In years
last birthday)

61

10. Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance Eng.

10B. KIND OF BUSINESS OR INDUSTRY

Hopkins Hospital

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Adam Jerscheid

14. MOTHER'S MAIDEN NAME

Caroline Cunzleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Zellick Jerscheid, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of Lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/4/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/7/67

23C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
2601 E. Madison St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 8526		BIRTH NO.		67 8526		CERTIFICATE OF DEATH		Registered No. 67 8526	
1. NAME OF DECEASED (Type or Print) HELEN M. NEUBERGER						2. DATE AND HOUR OF DEATH 9-5-67 12:25 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. (If not in hospital or institution, give street address or location)						4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-01 D. STREET ADDRESS (If rural, give location) 4204 MARY AVE #6					
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-5-96		9. AGE (In years last birthday) 70		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Austria XXXXXX			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME XXXXXXXX Zimmermann						14. MOTHER'S MAIDEN NAME HELENA UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. ?		17. INFORMANT Thomas Neuberger Husband			ADDRESS SAME		
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) Cerebral hemorrhage DUE TO Probable. (B) ASCVD DUE TO (C) ? HCV D			INTERVAL BETWEEN ONSET AND DEATH 6 hrs. ? ?		
						II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>9-4-1967</u> to <u>9-5-1967</u> , that (I) <u>we</u> last saw the deceased alive on <u>9-5-1967</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death.											
23A. SIGNATURE Frank Palmisano M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9-5-67		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Fisher, MA			25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			ADDRESS			

HELEN M. NEWBERRY

9-2-01

my

balls

Union Memorial Hosp. Hot Water Ave + V

F W MARRIED 10-2-00 To

MUSEWITZ - VIENNA A.S.A.

UNKNOWN SIMMONS HELEN UNKNOWN

UNKNOWN ? HUSBAND SAME

Cerebral Hemorrhage, 6 PM

Probable
Ascus

HEAD

NO
↓

Pharm. Laboratory

9-2

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9-2-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8527				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8527	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Bennett, Andrew H.		Sept. 5, 1967 8 45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
435 BALTO. Gen. Hosp.				Md.			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M		W					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Fireman				B.C.T. J.		Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNKNOWN						Family - Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) BRONCHOGENIC CA.		4 mo.	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from MAY 19 67 to SEPT. 5 19 67, that (I) (we) last saw the deceased alive on SEPT. 5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Thomas H. Emory						9/5/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
THOMAS H. EMORY				586 N.			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-9-67		Glen Haven Cem.		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 7 1967		Randy E. Jenkins		McGuire - 130 E. Fort Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.		67 8528		67 8528	
1. NAME OF DECEASED (Type or Print)		Betty G. Basinger		2. DATE AND HOUR OF DEATH 9-4-1967 2:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY G.G. Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hosp.		D. STREET ADDRESS (If rural, give location) 8444 Bay Drive Riviera Beach		5. SEX F 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH 2-2-1929 9. AGE (In years last birthday) 38 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY Housewife 11. BIRTHPLACE (State or foreign country) Melcroft, Pa. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Rubright		14. MOTHER'S MAIDEN NAME Elizabeth		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT George F. Basinger, Sr. ADDRESS SAME AS 4	
18. I 171 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) RECURRENT INTESTINAL OBSTRUCTION & MULTIPLE INTESTINAL FISTULA DUE TO (B) CARCINOMA OF CERVIX DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8-1-1967 to 9-4-1967, that (we) last saw the deceased alive on 9-4-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Larry J. Warner M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9/5/67	
23C. PHYSICIAN'S NAME (Type) Larry J. Warner M.D.				23D. ADDRESS 1213 Light St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/8/67		24C. NAME OF CEMETERY OR CREMATORY Normalville Cem. 24D. LOCATION (City, town, or county) (State) Normalville, Penna.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS TURKLEY Funeral Home, Burnie	

CHURCH OF CECILIA
WELSH METHODIST CHURCH
RECEIVED JANUARY 18 1890

John J. Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 8529	
BIRTH NO. 0		67 8529		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED <i>Minnie Balan</i>		2. DATE AND HOUR OF DEATH <i>September 5/67 11⁴⁵ A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>21-20</i>			
		D. STREET ADDRESS (If rural, give location) <i>7037 Surrey Drive</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>May 1, 1891</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Solomon Rosen</i>		14. MOTHER'S MAIDEN NAME <i>Rachel</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Evelyn Adler - 6611 Marrett Drive</i>	
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Anterograde to HT Dis</i> DUE TO (B) <i>Heart Failure</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i> <i>8 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/9 50</i> to <i>9/5 67</i> , that (I) (we) lost saw the deceased alive on <i>8/28/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sol Smith</i>				23B. DATE SIGNED <i>9/6/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>SOL SMITH</i>		23D. ADDRESS <i>2500 EUTAW PLACE Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sept 6/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Hebrew Young Men</i>	
24D. LOCATION <i>Windsor Mead Road</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 7 1967</i>		25B. NAME OF REGISTRAR <i>John E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Solomonson</i>		25D. ADDRESS <i>6010 Reest Road</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 8530		CERTIFICATE OF DEATH				Registered No. 67 8530				
1. NAME OF DECEASED (Type or Print) FURMAN, SAMUEL					2. DATE AND HOUR OF DEATH SEPT-1-1967 7.18 AM.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 7619 CARLA RD. #8					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) unmarried		8. DATE OF BIRTH 4-1-97	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10B. KIND OF BUSINESS OR INDUSTRY AUTO PARTS		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME LOUIS FURMAN				14. MOTHER'S MAIDEN NAME UNKNOWN						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I			16. SOCIAL SECURITY NO.		17. INFORMANT MRS. IDA FURMAN, 7619 CARLA ROAD #9				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.11+260X (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE RENAL FAILURE					INTERVAL BETWEEN ONSET AND DEATH 48h.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. cardiogenic shock					(B) DUE TO ACUTE Diaphragmatic myocardial infarction.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II DIABETES MELLITUS										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8-28-1967 to 9-1-1967 , that (I) (we) last saw the deceased alive on 9-1-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE F. S. Sauer					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED SEPT-1-67			
23C. PHYSICIAN'S NAME (Type) FRANCISCO SAUER					23D. ADDRESS SINAI HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/1/67		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR SQL LEVINSON & BROS. INC., 6010 REIST., RD.				

UNCLASSIFIED

FILE #

100

DATE OF BIRTH

DATE OF DEATH

DATE OF ENTRY

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 8531		67 8531	
BIRTH NO.		M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		Registered No.	
LESTER HARRIS		8/31/67		3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MD.		B. COUNTY	
FRANKLIN SQUARE HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTO	
D. STREET ADDRESS (If rural, give location)		1100 BORN ST.		18-02	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M		N		SEP.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER				CHESTER S.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
ANDY HARRIS		ANNA LILLY		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		?		FSA RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331 X1		Cerebro Vascular Accident		?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/30 to 8/31 1967, that (I) (we) last saw the deceased alive on 8/30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Hector Feliciano		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		8/31/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HECTOR FELICIANO		M.D. FRANKLIN SQ. HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9/5/67		Mt Calvary	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Baltimore		M. J. P. August 68 N. G. L. M. O. S.		21225	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
SEP 7 1967		R. G. E. Johnson		21225	

1
P-400

67 8532

BALTIMORE CITY HEALTH DEPARTMENT

67 8532

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
JAMES

H.

POWELL

2. DATE AND HOUR PRONOUNCED DEAD

August 31, 1967

11:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

209 N. Mount Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

209 N. Mount Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

JAN 20 1899

9. AGE (in years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life even if retired)

RETIRED MEAT CUTTER WHOLE MEATS

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES HENRY POWELL

14. MOTHER'S MAIDEN NAME

SARAH COOPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ALICE WINSTON 1547 HOMESTEAD ST

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

422.1
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/1/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

9/6/67

23C. NAME OF CEMETERY or CREMATORY

WESTERN STAR

23D. LOCATION

(City, town, or county)

(State)

CATONSVILLE MD

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

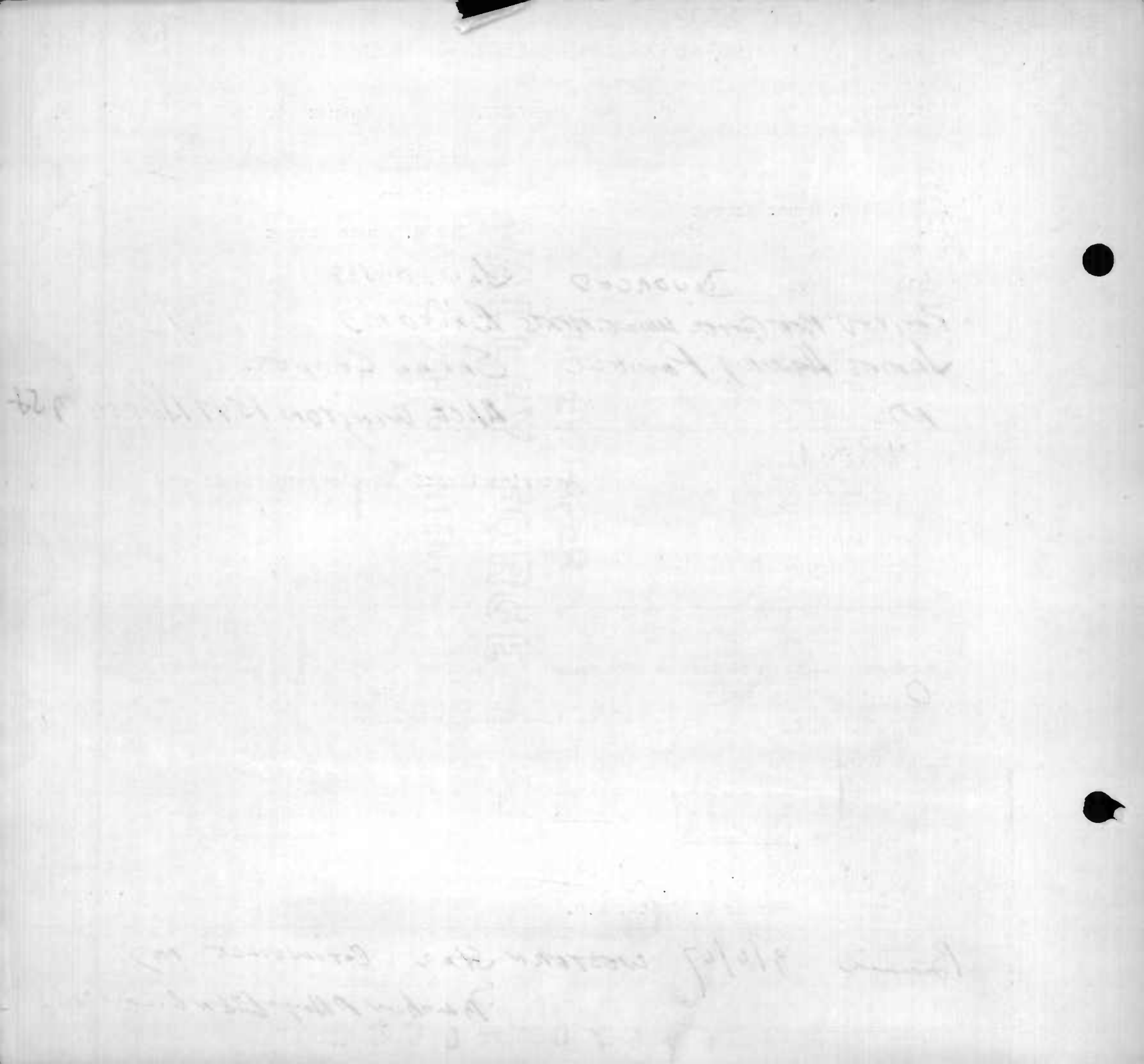
24C. FUNERAL DIRECTOR

ADDRESS

SEP 7 1967

Robert E. Faldut

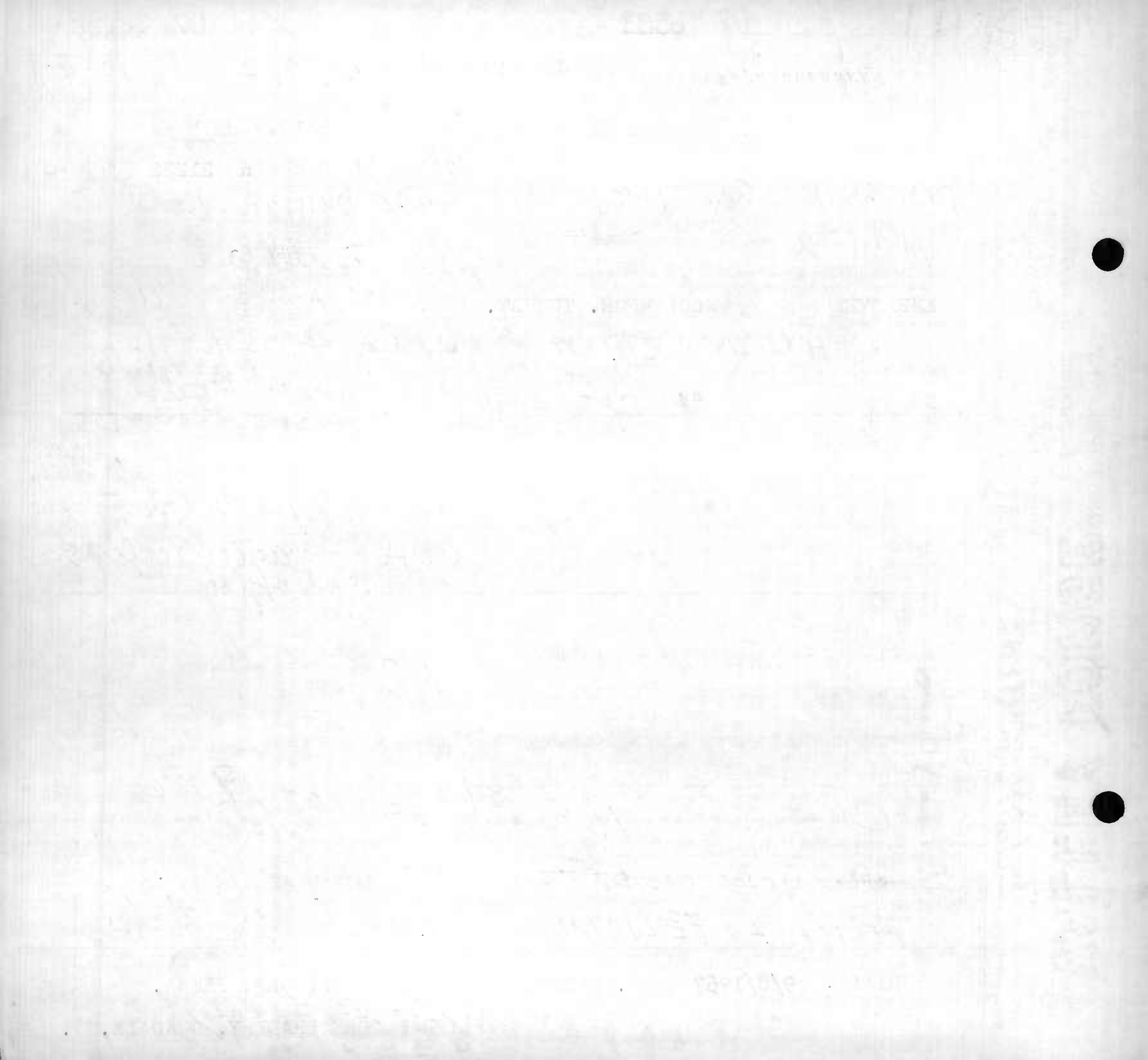
Marshall P. Hays 638 N. Gilman St



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8533		CITY HEALTH DEPARTMENT		Registered No. 67 8533	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) XXXXXXXXXXXXXXXXXXXX SAM JOHN MARTIN		2. DATE AND HOUR OF DEATH 9/6/67 12:40 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) XXXXXXXXXX DUNDALK 21222 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQ. HOSP		D. STREET ADDRESS (If rural, give location) 3420 Dunbar road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1/26/84	9. AGE (In years lost birthday) 83	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE		10B. KIND OF BUSINESS OR INDUSTRY WOOL MFG. INDUST.		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN MARTINI		14. MOTHER'S MAIDEN NAME ANNA MOLINCHUK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ## 025 100049		17. INFORMANT ADDRESS HOSP. RECORDS	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Respiratory & Cardiac Failure CVA 2° arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH - 34 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/3 1967 to 9/6 1967, that (I) (we) lost saw the deceased alive on 9/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Hector L. Feliciano		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/6/67	
23C. PHYSICIAN'S NAME (Type) HECTOR L. FELICIANO		23D. ADDRESS FRANKLIN SQ. HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/8/1967		24C. NAME OF CEMETERY ST. NICHOLAS	
24D. LOCATION (City, town, or county) (State) PRINGLE, PENNA.		25A. DATE RECEIVED BY HEALTH DEPT. SEPT 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR WALTER BROOKS BRADLEY		25D. ADDRESS DUNDALK, MD.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8534

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARIE

L. WALTON

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1967 1:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1847 Spring St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1847 Spring St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

SEPARATED

8. DATE OF BIRTH

7/8/1917

9. AGE (In years last birthday)

50

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALES

10B. KIND OF BUSINESS OR INDUSTRY

Retail

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

EDWARD LIVINGSTON

14. MOTHER'S MAIDEN NAME

MAMIE HOGGAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

219-12-5988

17. INFORMANT

ADDRESS

CELIA L. COUSIN'S - 961 N. Rose Dale St.

18.

322.01

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Acute Alcohol Intoxication

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U Spitz, J.M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/4/67

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

9/7/67

23C. NAME of CEMETERY or CREMATORY

CARVER MEMORIAL

23D. LOCATION

(City, town, or county)

LAUREL

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

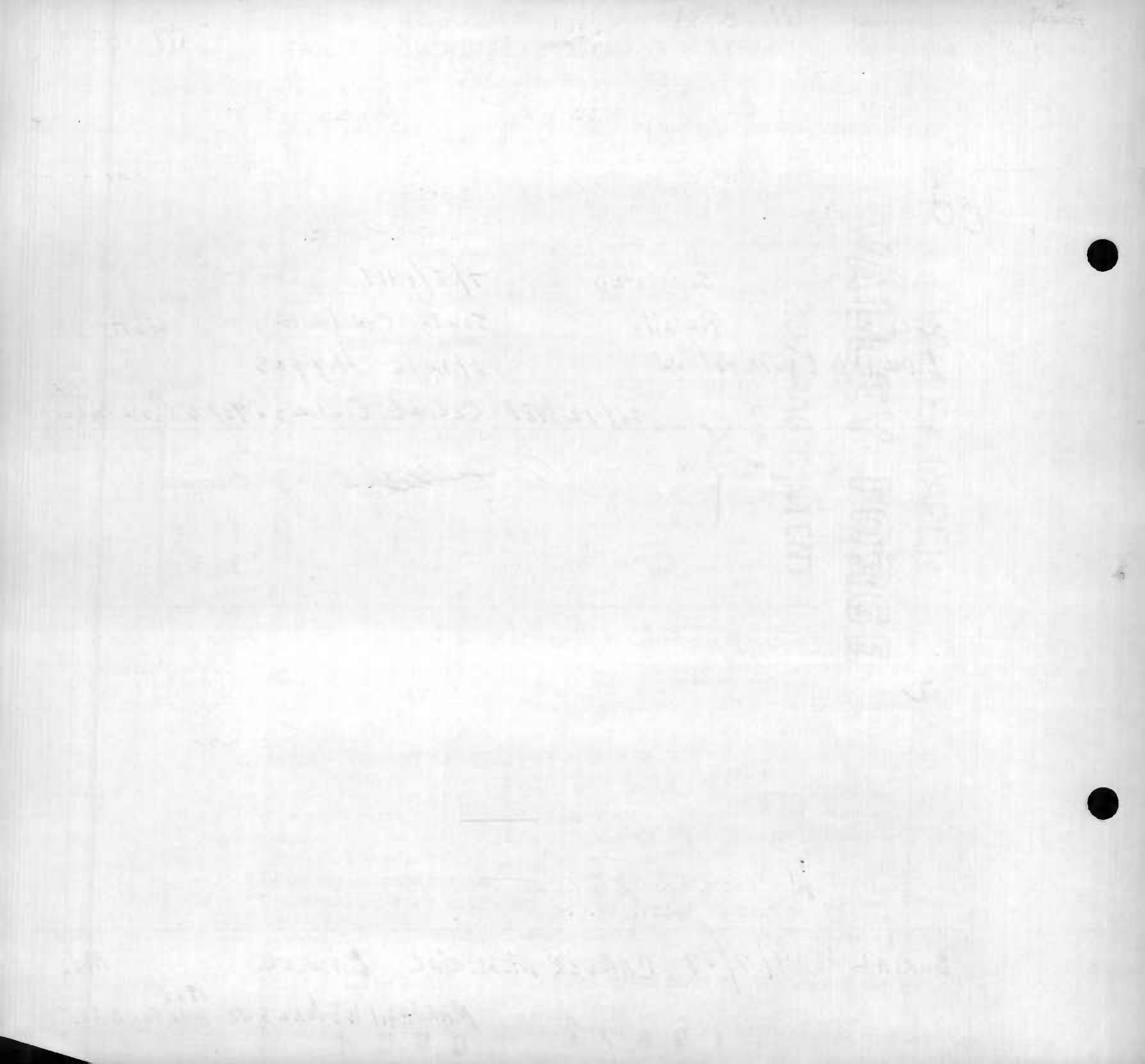
24C. FUNERAL DIRECTOR

ADDRESS

SEP 7 1967

R. G. E. Jones

MARSHALL W. JONES, Jr. 1835 HARFORD AVE.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>67 8535</u>	
BIRTH NO. <u>67 8535</u>		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>NORMAN P FLOCK</u>				2. DATE AND HOUR OF DEATH <u>Sept 4, 1967</u> <u>8:10</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u> <u>2025 West Fayette St</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>3038 Stafford St</u> <u>20-06</u>			
				D. STREET ADDRESS (If rural, give location) <u>Baltimore Md 21223</u>			
5. SEX <u>Male</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>9/16/94</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret, home</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pittsburgh Plate Glass Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Philip Flock</u>				14. MOTHER'S MAIDEN NAME <u>Anna Beckman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>213-05-3070-A</u>		17. INFORMANT <u>Mrs. Edna E. Flock</u>		ADDRESS <u>3038 Stafford St. Balto. Md.</u>	
18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Chronic heart failure</u> DUE TO (B) <u>A.S.C.U.D.</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>months.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> 19 <u>67</u> to <u>9/4</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edna E. Flock</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/4/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>CESAR A. BRAVO</u>				23D. ADDRESS <u>Bon Secours Hospital.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept. 7, 1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>G. Truman Schwab</u>		ADDRESS <u>3512 Frederick Ave. Balto. Md.</u>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 8536		X		67 8536	
BIRTH NO.				Registered No.			
M.E. CASE NO.							
1. NAME OF DECEASED (Type Print) TERESA WOODS				2. DATE AND HOUR OF DEATH 9/3/67 5:00 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL				A. STATE MARYLAND B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229			
				D. STREET ADDRESS (If rural, give location) 4301 ALAN DRIVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 3/17/93	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-US GOVT.		10B. KIND OF BUSINESS OR INDUSTRY U S GOVERNMENT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD WOODS				14. MOTHER'S MAIDEN NAME CULLEN Anne			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 44 5080		17. INFORMANT CATON		ADDRESS WILKENS & EDDY AVES	
18. 2041 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE GRANULOCYTIC LEUKEMIA				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4-5 MONTHS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 9/3		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/4 1967 to 9/3 1967 , that (I) (we) last saw the deceased alive on 9/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <i>R. Revilla</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/3/67	
23C. PHYSICIAN'S NAME (Type) DR. RODOLFO M. REVILLA				23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 6, 1967		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR <i>Robert G. F...</i>		25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 3512 Frederick Ave. Balto. Md.	

VERONA WOODS

ST AGNES HOSPITAL

F. W.

RETIRED-US GOVT.

EDWARD WOODS

NO

U.S. GOVERNMENT

MARIAL NO.

USA

CULLEN

320 44 2080

ST AGNES RECORDS - WILKINS

DR. RODOLFO M. REVILLA

Dept. 5, 1st Fl. Cathedral

Cardel

1957

3/3/57

ST. AGNES HOSPITAL CAYON 2 WILKINS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		67 8537		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8537	
1. NAME OF DECEASED (Type or Print) SMITH, GEORGE Washington				2. DATE AND HOUR OF DEATH 9/3/67 2:12 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3605 HAYWARD AVE. 21215			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-22-83	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY W. M. R. R.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (No Record) Smith				14. MOTHER'S MAIDEN NAME Elma Gigous			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. A 499513		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224 MD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO From negative x-rays & autopsied pneumonia (B) DUE TO Squamous cell carcinoma lung (C)		INTERVAL BETWEEN ONSET AND DEATH 30 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8/29/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bronchoscopy to r/c carcinoma		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/25 19 67 to 9/3 19 67, that (I) (we) last saw the deceased alive on 9/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Leonard Lippman				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/3/67	
23C. PHYSICIAN'S NAME (Type) DR. LEONARD LIPPMAN				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. 21224, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 6/67		24C. NAME OF CEMETERY or CREMATORY Rose Hill Cemetery		24D. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Andrew K. Coffman Funeral Home INC. Hagerstown, Maryland,			

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
RUBY

K.

TEAGUE (TAYLOR)

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1967

9:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hosp. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1432 W. Baltimore St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

2/20/35

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

---- Knight

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr. Kenneth Taylor
929 Rock Mill Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) *Acute Myocardial Infarction*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.*Fatty Alteration of Liver*

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that, I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/8/67

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION (City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

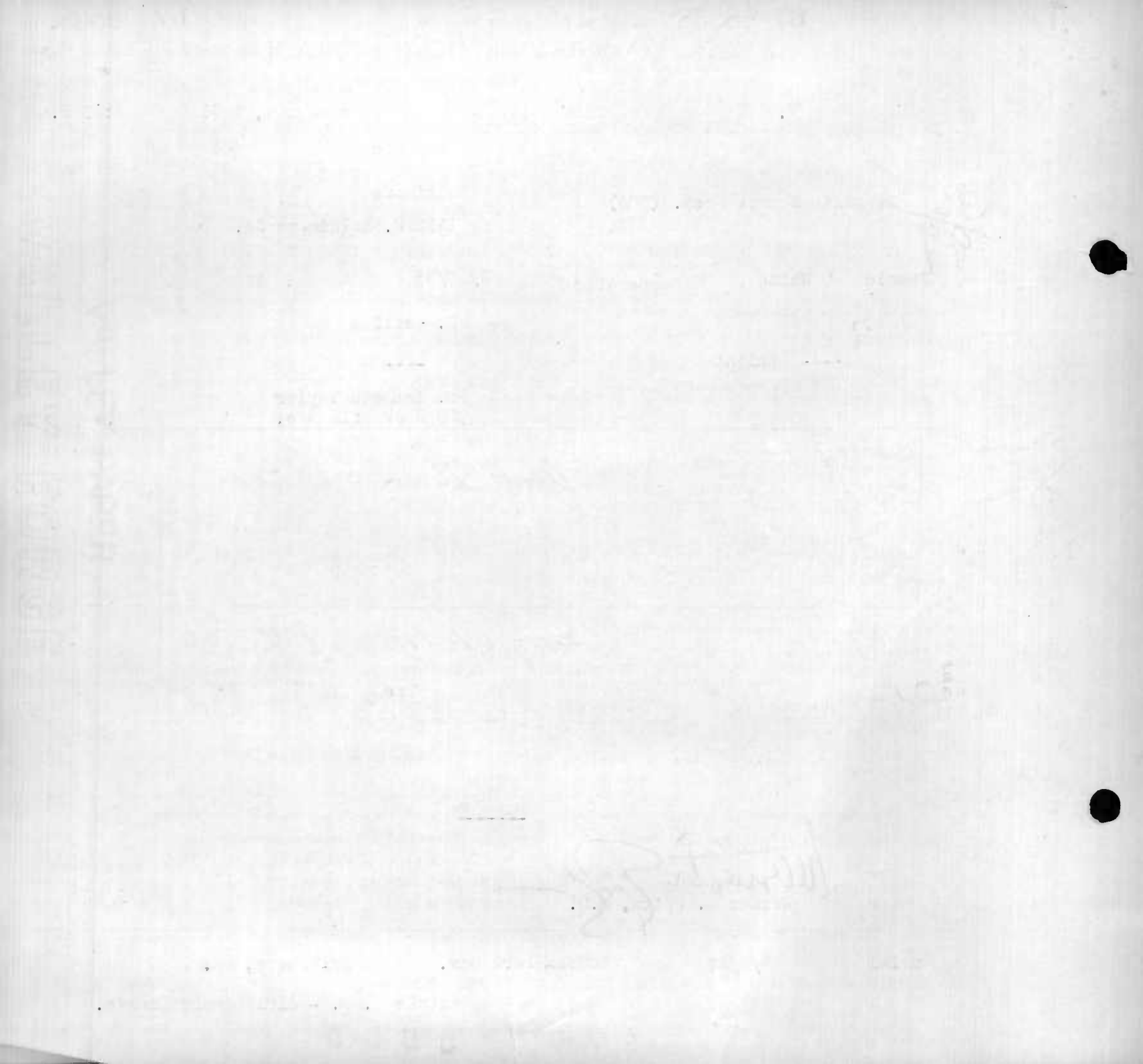
24C. FUNERAL DIRECTOR

ADDRESS

SEP 7 1967

R. E. Farley, M.D.

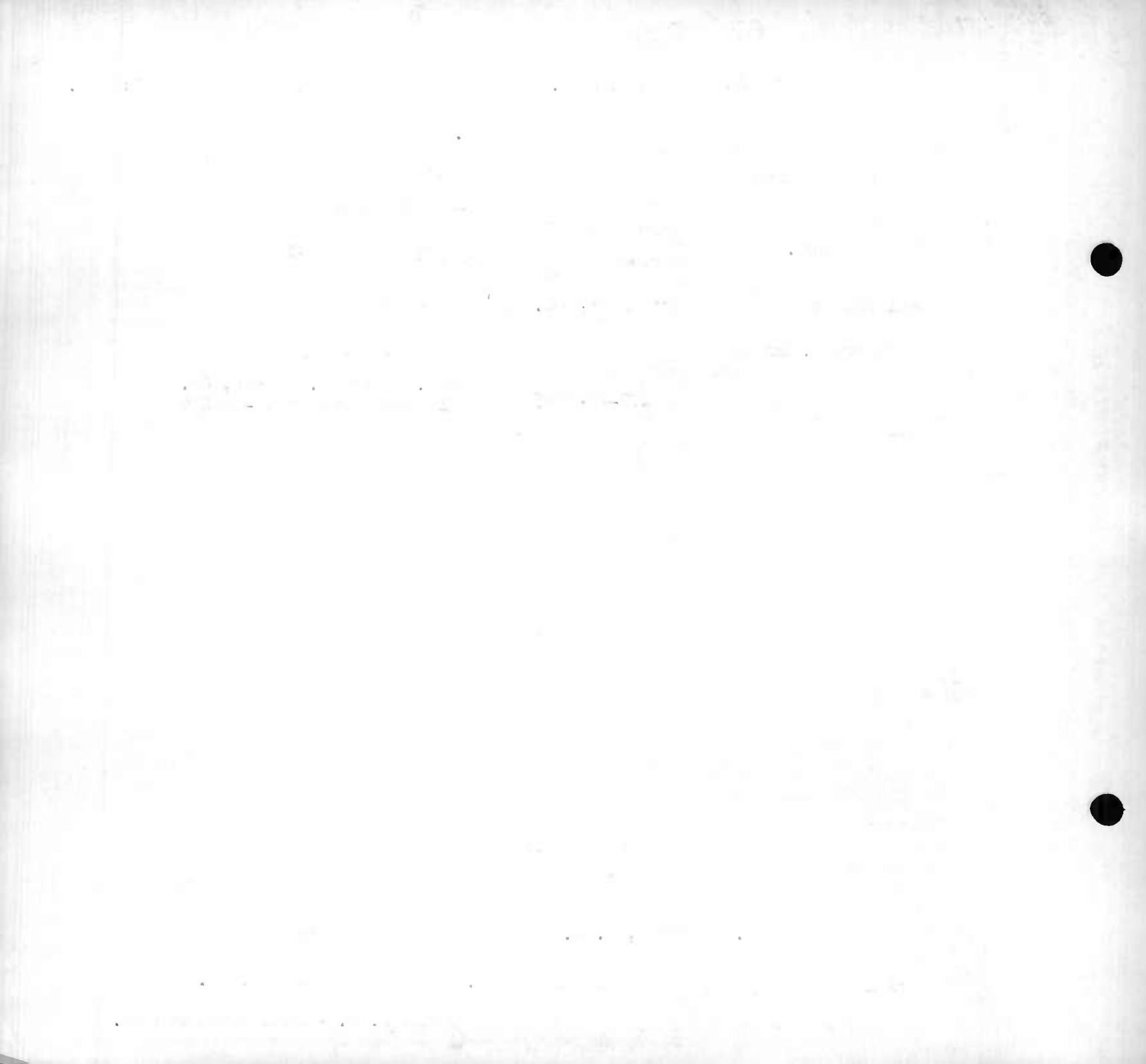
Witzke F. D. - 4101 Edmondson Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8539</u>	
BIRTH NO. <u>67 8539</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Edward Maitland Duvall, Jr.</u>		2. DATE AND HOUR OF DEATH <u>9/5/67</u> <u>2:15 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>510 Rock Glen Road</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, give RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>510 Rock Glen Road</u>			
5. SEX <u>M</u>	6. RACE <u>Cauc.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8/1/05</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nora Cloney Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward M. Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Avondale Disney</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>172-09-0705</u>		17. INFORMANT <u>Mrs. Edward M. Duvall, Jr.</u> <u>510 Rock Glen Road - 21229</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.11-260X</u> CAUSE OF DEATH <u>CORONARY OCCLUSION - ACUTE MYOCARDIAL INFARCTION</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>A-CVH-D</u> <u>1 YR.</u>		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>DIABETES MELLITUS</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 1</u> 19 <u>57</u> to <u>SEPT. 5</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>AUG. 15</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John F. Schaefer</u>				23B. DATE SIGNED <u>Sept. 6 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>John F. Schaefer, M.D.</u>		23D. ADDRESS <u>401 Random Road</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/7/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1967</u>			
25B. NAME OF REGISTRAR <u>John F. Schaefer</u>		25C. FUNERAL DIRECTOR <u>Witzke F. D.</u> <u>4101 Edmondson Av.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

65-10000

10:00

MILLER, CAROL

DATE OF BIRTH

1925

1234567890

3-12-02

USE

WIFE

1000000000

HOSPITAL RECORDS - ST. ANNE'S HOSPITAL -
2401 AND WILKINS AVENUE - ST. LOUIS, MO.

ST. ANNE'S HOSPITAL
2401 AND WILKINS AVENUE
ST. LOUIS, MO. 63103

REMALE WHITE WIDOWED

HOUSEWIFE NONE

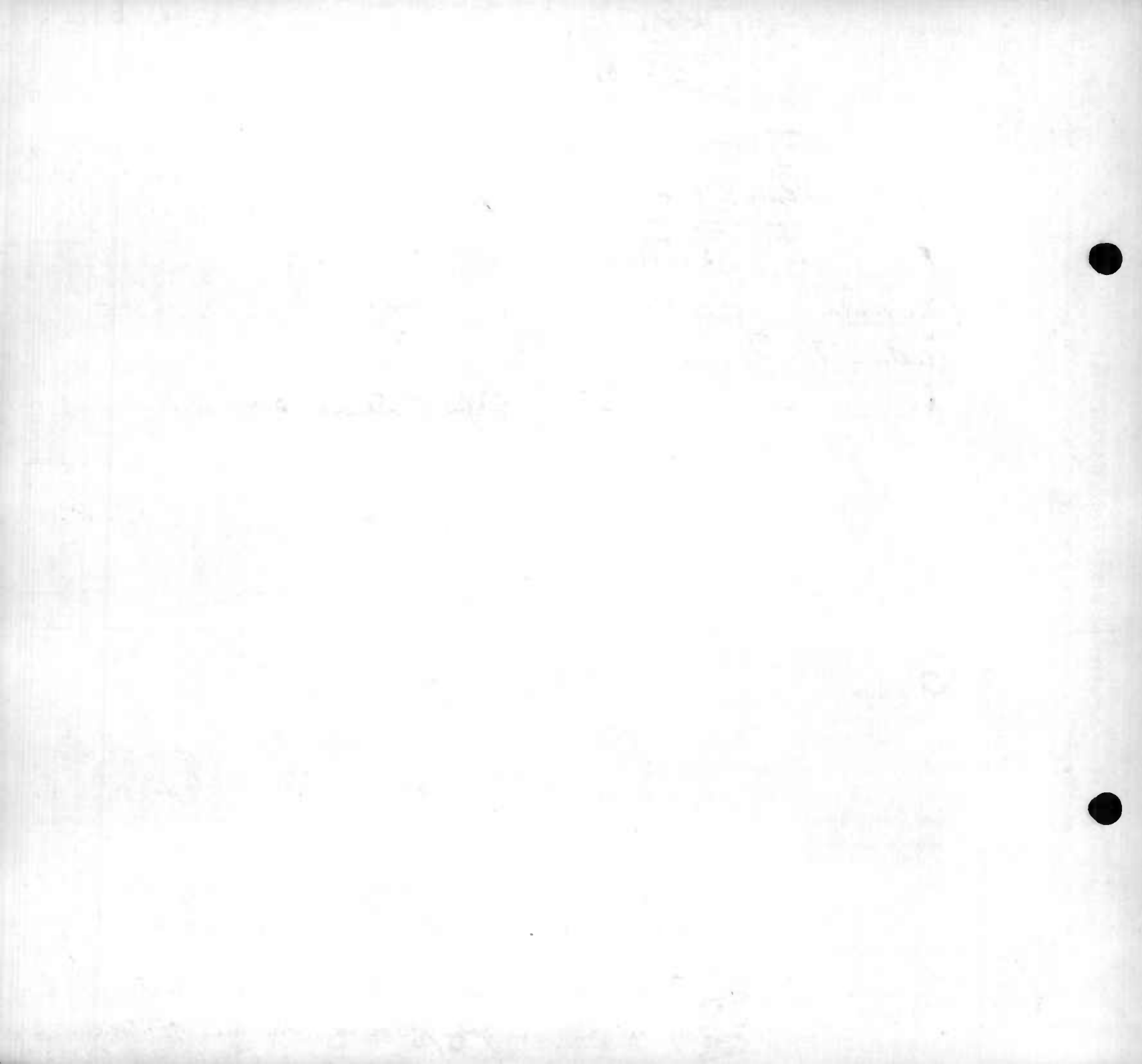
1000000000

UNKNOWN UNKNOWN

65-10000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

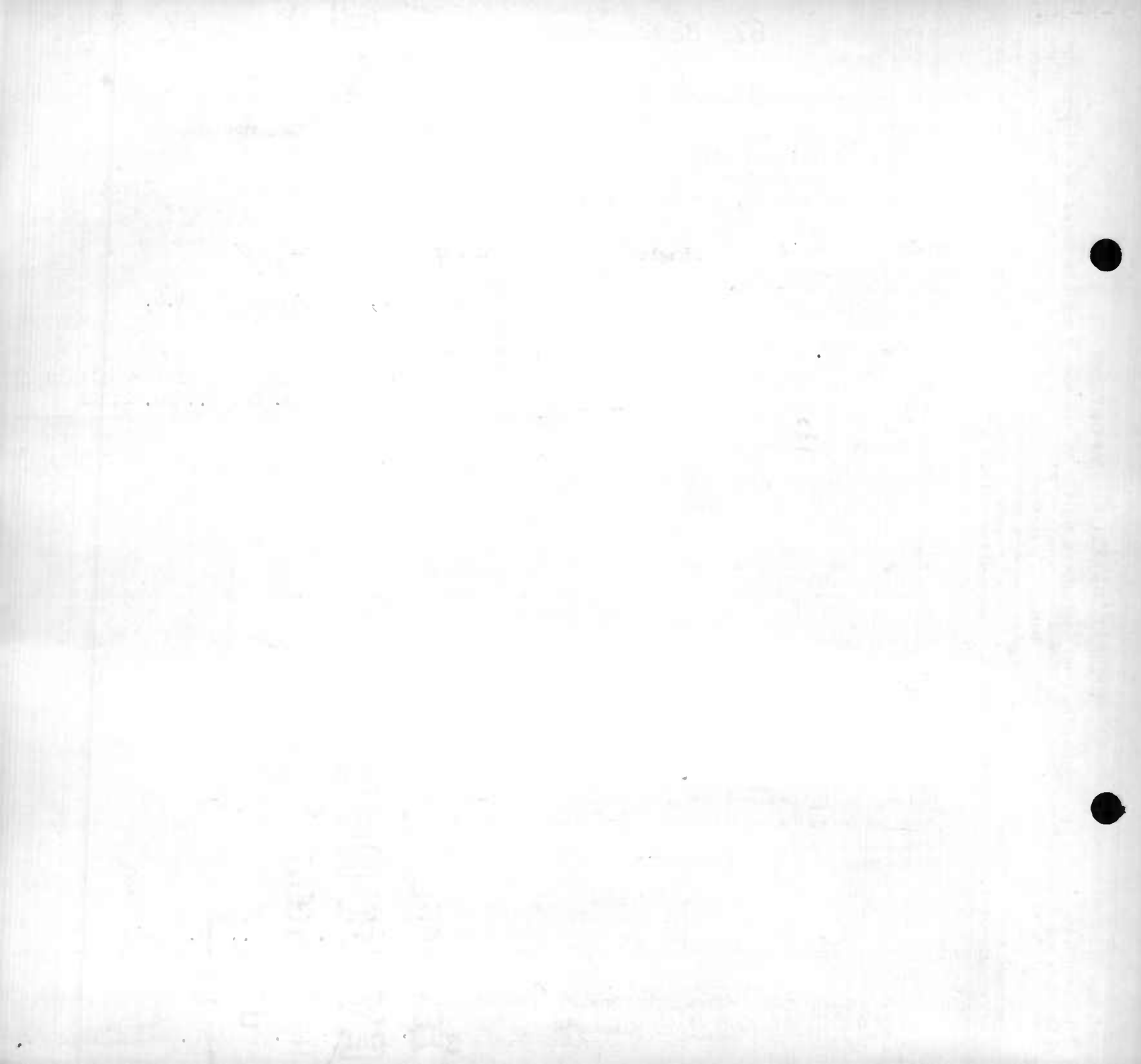
BIRTH NO. 67 8541		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8541	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) KATHERINE G. SEIBER		2. DATE AND HOUR OF DEATH 9/5/67 7 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 2105 Wilkens Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		19-03	
		D. STREET ADDRESS (If rural, give location) 1332 HOLLINS ST. (21223)			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/10/1908	9. AGE (In years last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar maid
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar maid		10B. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (State or foreign country) Ind.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Wood		14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -	17. INFORMANT Ellis C. Seiber - 2243 Wilkens Ave (21223)		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) + 43X I ASCVD Hypertension		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2-3 years 2-3 years	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Sept 5 1966 to Sept 5 1967, that (1) (we) last saw the deceased alive on Sept 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE HIROSHI NAKAZAWA		23B. DATE SIGNED Sept. 5. 1967			
23C. PHYSICIAN'S NAME (Type) HIROSHI NAKAZAWA		23D. ADDRESS 3350 Wilkens Ave Balto 29			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/67		24C. NAME of CEMETERY or CREMATORY St. John the Evangelist	
24D. LOCATION (City, town, or county) Clinton, Md.		24E. NAME of REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR John J. Cowan	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Cowan	
25D. ADDRESS 901 Hollins St. Balto Md (21223)					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

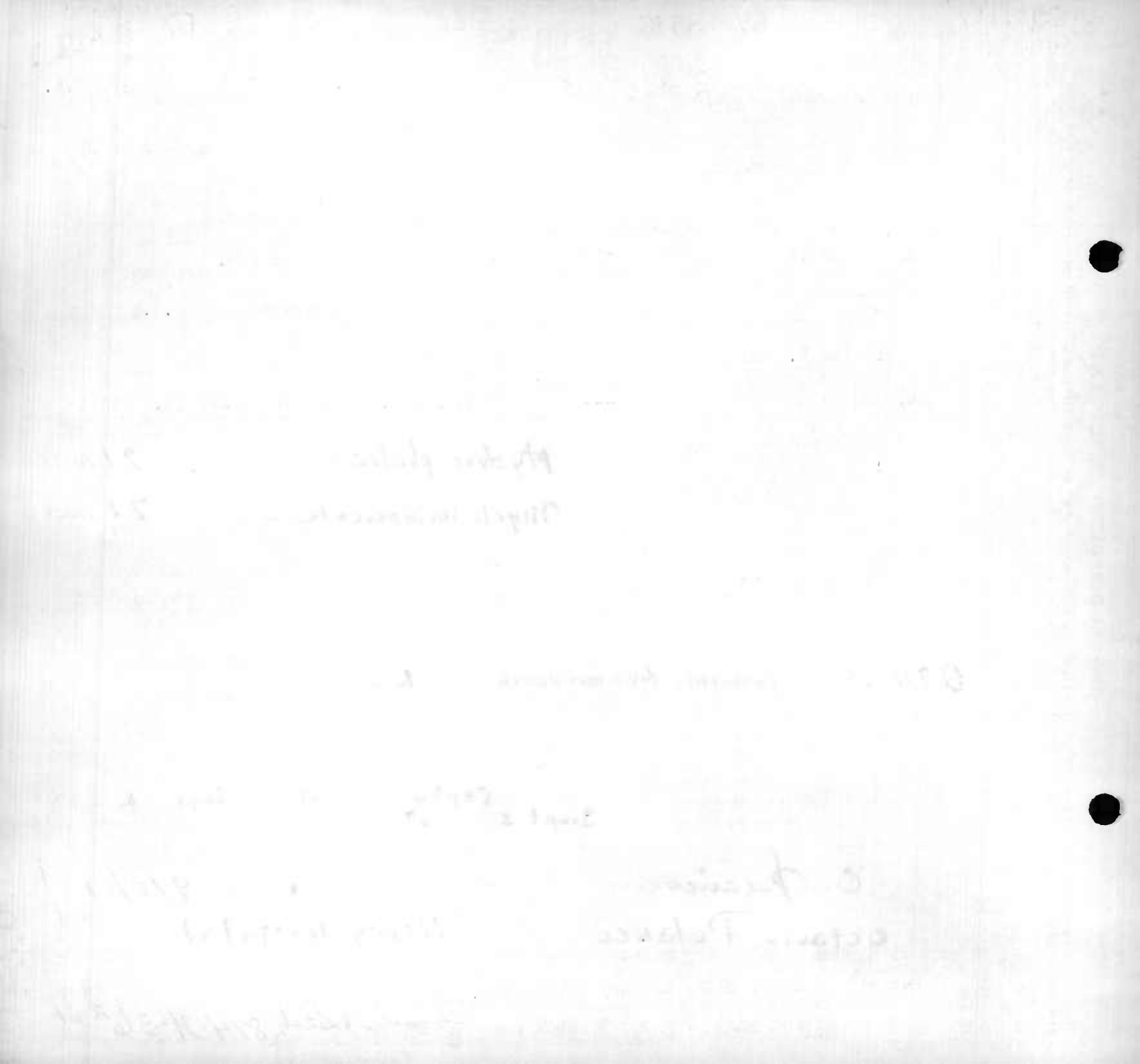
H-153 BIRTH NO. 67 8542		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8542	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EDITH HOFFMAN			2. DATE AND HOUR OF DEATH 9-4-67 2 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-44 D. STREET ADDRESS (If rural, give location) 21224 3520 E. FAIRMOUNT AVE		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5-4-19	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore	
13. FATHER'S NAME Joseph A.			14. MOTHER'S MAIDEN NAME Anna Sparr		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-72-2885		17. INFORMANT Records: Baltimore City Hospitals 4940 Eastern Ave. Balto., Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible Urinal Illness			CAUSE OF DEATH (A) CARDIAC + RESPIRATORY ARREST DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HRS
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-4 1 PM 19 67 to 9-4 2 PM 19 67, that (I) (we) last saw the deceased alive on 9-4 2 PM 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Cordes			23B. DATE SIGNED 9-4-67		
23C. PHYSICIAN'S NAME (Type) ROBERT A. CORDES			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Balto., Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/67		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Moran, Inc. 3000 E. Baltimore St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

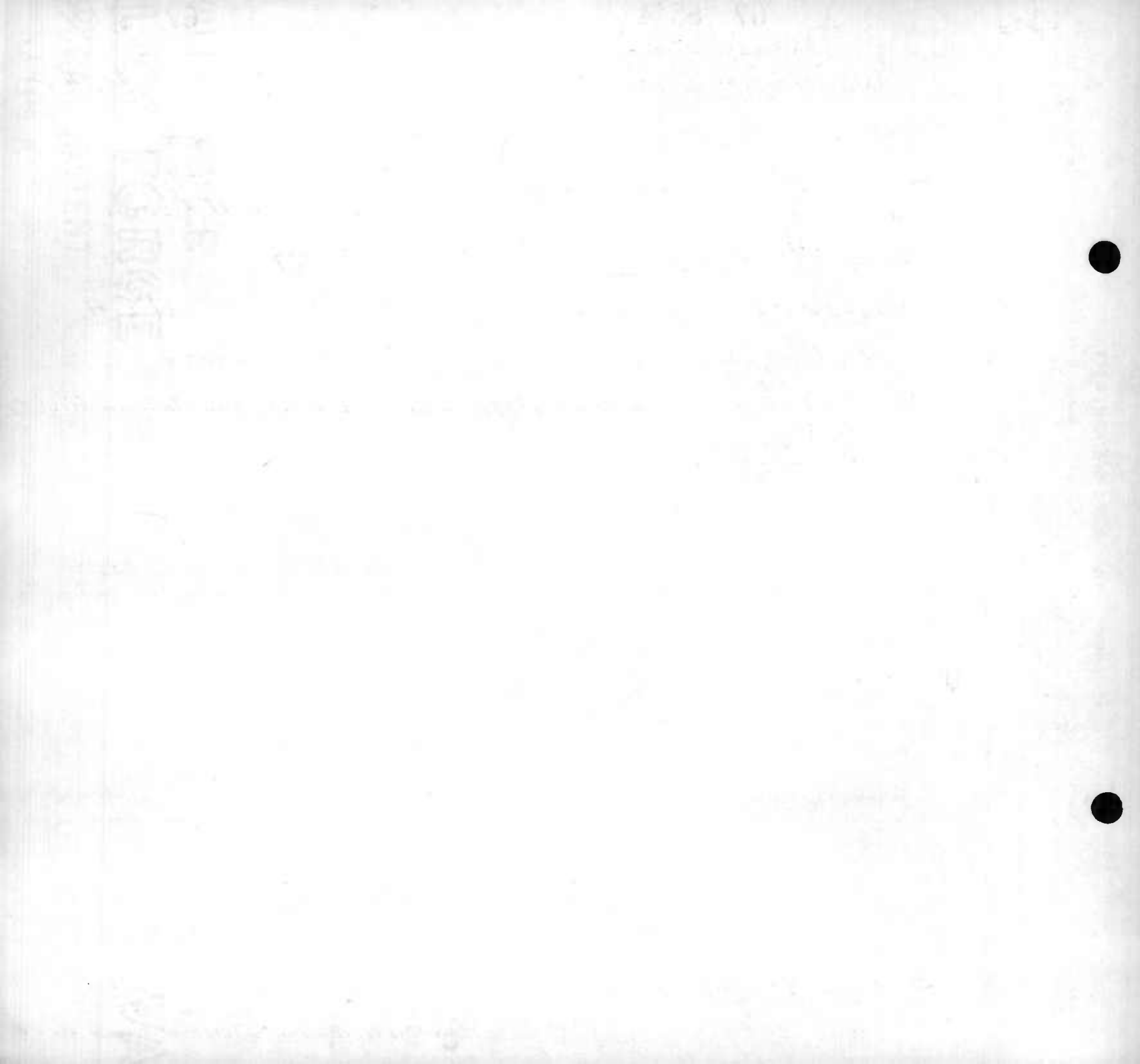
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. <u>65-24117 67 8543</u>					CERTIFICATE OF DEATH					Registered No. <u>67 8543</u>				
1. NAME OF DECEASED (Type or Print) <u>William G. Wiles</u>										2. DATE AND HOUR OF DEATH <u>Sept. 5, 1967</u> <u>9:30 P.M.</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital</u>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>826 West 33rd Street</u>				
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Oct 19, 1965</u>		9. AGE (In years last birthday) <u>1 yrs.</u>		If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>William E. Wiles</u>						14. MOTHER'S MAIDEN NAME <u>Mackey</u>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT ADDRESS <u>William E. Wiles 826 W 33rd St. 21211</u>								
18. <u>757.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Hydrocephalus -</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Myelo-meningocele -</u>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>21 mos.</u> <u>22 mos.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <u>9/6-65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Connection Myelo-meningocele</u>				20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 4</u> 19 <u>67</u> to <u>Sept 5</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 5</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>O. Polanco</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <u>9/5/67</u>						
23C. PHYSICIAN'S NAME (Type) <u>Octavio Polanco</u>						23D. ADDRESS M.D. <u>Mercy Hospital</u>								
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sep 8, 1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley Mem. Gardens</u>				24D. LOCATION (City, town, or county) (State)						
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1967</u>				25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>				25C. FUNERAL DIRECTOR ADDRESS <u>Frank White 814 N. 36th St</u>						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8544		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8544	
M.E. CASE NO.		1. NAME OF DECEASED (Antonia) (ANTONIA)		2. DATE AND HOUR OF DEATH 9-6-67 10:14 P.M.	
1. NAME OF DECEASED (Type or Print) Walterhofer Anna Mrs.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hosp.		A. STATE Maryland.		B. COUNTY 28-04	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21229		D. STREET ADDRESS (If rural, give location) 204 Mallow Hill Road.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed.	8. DATE OF BIRTH 12/16/87	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Balto Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Theo. Meyers.		14. MOTHER'S MAIDEN NAME Catherine Schoen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 212-20-4747D		17. INFORMANT LILLIE DEGENER 204 MALLOW HILL RD	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Massive Pulmonary Embolism DUE TO (B) Congestive Heart Failure DUE TO (C) Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Intestinal Obstruction with Mesenteric Thrombosis		19A. DATE OF OPERATION 9/5/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 1 1967 to September 6 1967, that (I) (we) last saw the deceased alive on Sept. 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rene O. Santiago M.D.		23B. DATE SIGNED Sept. 6, 1967			
23C. PHYSICIAN'S NAME (Type) RENE O. SANTIAGO M.D.		23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-67		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION BALTIMORE Md		25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR R. O. Santiago	
25C. FUNERAL DIRECTOR GEO. L. SCHWAB FUNERAL HOME		25D. ADDRESS 2101 Rutland Ave			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **ARTHUR JOYNER** 2. DATE AND HOUR PRONOUNCED DEAD **September 5, 1967** | **5:30 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **7-04**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
1034 McDonough Street D.O.A. Baltimore

D. STREET ADDRESS (If rural, give location) **1034 McDonough Street**

5. SEX **Male** 6. RACE **Colored** 7. MARRIED, NEVER MARRIED, WIDOWED, (DIVORCED (specify)) **Never Married** 8. DATE OF BIRTH **Nov 4, 1906** 9. AGE (in years last birthday) **60** If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Unemployed** 10B. KIND OF BUSINESS OR INDUSTRY **Unemployed** 11. BIRTHPLACE (State or foreign country) **Orangeburg SC** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **George Joyner** 14. MOTHER'S MAIDEN NAME **Isabelle Walker**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **Mr. Kenner 4214 Fleming Drive** ADDRESS

18. **422.1** CAUSE OF DEATH (A) **Arteriosclerotic Cardiovascular Disease** DUE TO (B) DUE TO (C) DUE TO

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **NO** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER **Russell S. Fisher, M.D.** DATE SIGNED

ACTUAL SIGNATURE **Russell S. Fisher, M.D.** ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **Sept 8 / 67** 23C. NAME of CEMETERY or CREMATORY **Westport Md** 23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT. **SEP 7 1967** 24B. NAME OF REGISTRAR **Robert E. Fisher** 24C. FUNERAL DIRECTOR **Paul E. Lukson 1129 S. Calver St** ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department			
67 8546		Registered No. 67 8546	
BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) BERTHA KOTOWSKI (BRONISLAWA KOTOWSKA)		2. DATE AND HOUR OF DEATH Sept. 6, 1967 6:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 1923 FLEET ST. BALTO. MD. 21231		A. STATE MD. B. COUNTY 21231	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.	
		D. STREET ADDRESS (If rural, give location) 1923 FLEET ST.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, WIDOWED.	8. DATE OF BIRTH 12-26-93
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10B. KIND OF BUSINESS OR INDUSTRY CANNERY	9. AGE (In years last birthday) 73
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? POLAND	
13. FATHER'S NAME ANTHONY JAWORSKI		14. MOTHER'S MAIDEN NAME MICHALINA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-9808	
17. INFORMANT STELLA WYCZALEK		ADDRESS 1923 FLEET ST. BALTO. MD. 21231	
18. 422.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Insufficiency		CAUSE OF DEATH (A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Chronic Myocarditis	
		(C) DUE TO Chronic Arthritis	
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		6 yrs.	
10 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1940 to Sept. 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John V. Sczerbicki		23B. DATE SIGNED 9-6-67	
23C. PHYSICIAN'S NAME (Type) JOHN SCZERBICKI MD		23D. ADDRESS 1802 Eastern Ave 20231	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE SEPT. 9, 1967	
24C. NAME OF CEMETERY or CREMATORY Holy Rosary Ccm.		24D. LOCATION (City, town, or county) (State) BALTO. Co. MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR W. FIALKOWSKI	
25C. FUNERAL DIRECTOR 2007 EASTERN AVE. BALTO. MD. 21231		ADDRESS	

Chronic Bronchitis
Chronic Nephritis
Chronic Gastritis

17. Sept. 1892

Dr. W. B. B. B.

John W. B. B.

1802 Eastern Ave

B-235

67 8547

BALTIMORE CITY HEALTH DEPARTMENT

67 8547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED ANN BOSTON

2. DATE AND HOUR PRONOUNCED DEAD

September 1, 1967 10:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 447 Pitman Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

447 Pitman Place

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

2-19-1919

9. AGE (in years last birthday)

48

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lawrence Boston

14. MOTHER'S MAIDEN NAME

Jessie Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Jessie Henderson 447 Pitman Place

18.

420.01

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)

Arteriosclerotic heart disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 2, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/6/67

23C. NAME OF CEMETERY or CREMATORY

Carrer Memorial Park

23D. LOCATION

(City, town, or county) (State)

Prince Geo to Md

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1967

24B. NAME OF REGISTRAR

Robert E. Fairbairn

24C. FUNERAL DIRECTOR

Rayner Sanders

ADDRESS

217 E. Preston St

WILLIAM H. HAZEN
OF THE COUNTY OF HAMPDEN
STATE OF MASSACHUSETTS

James M. Hazen

Attorney at Law

2-17-1893
James M. Hazen
Attorney at Law

James M. Hazen
Attorney at Law

T-656

BIRTH NO. 67 8548		BALTIMORE CITY HEALTH DEPARTMENT		67 8548	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
1. NAME OF DECEASED (Type or Print) MILBURN TURNER			2. DATE AND HOUR PRONOUNCED DEAD September 4, 1967 2:10 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2222 N. Monroe St. (DOA)			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 15-04 D. STREET ADDRESS (If rural, give location) 2222 N. Monroe St.		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10/11/25	9. AGE (In years last birthday) 41	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Jackson		
14. MOTHER'S MAIDEN NAME Marion Turner			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 220-14-6492			17. INFORMANT Marion Turner 512 Archer St.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 21			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/5/67					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9/8/67	23C. NAME OF CEMETERY or CREMATORY Baltimore National		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland
24A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.		24C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.	

WILLIAM F. BORDO

WILLIAM F. BORDO

WILLIAM F. BORDO

[Handwritten signature]

1
A-352

67 8549

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8549

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELSIE ADAMS

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1967

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Annapolis

D. STREET ADDRESS (If rural, give location)

28 Pleasant St.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9-23-1910

9. AGE (In years last birthday)

56

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Brooks

14. MOTHER'S MAIDEN NAME

Rosie Foote

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

21826-0913

17. INFORMANT

Joseph Adams Annapolis

ADDRESS

18. E90010

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

28 Pleasant St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

9 3 67 ?

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Subject fell down steps

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

September 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9-9-67

23C. NAME OF CEMETERY or CREMATORY

Pine Lawn

23D. LOCATION (City, town or county)

Annapolis

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

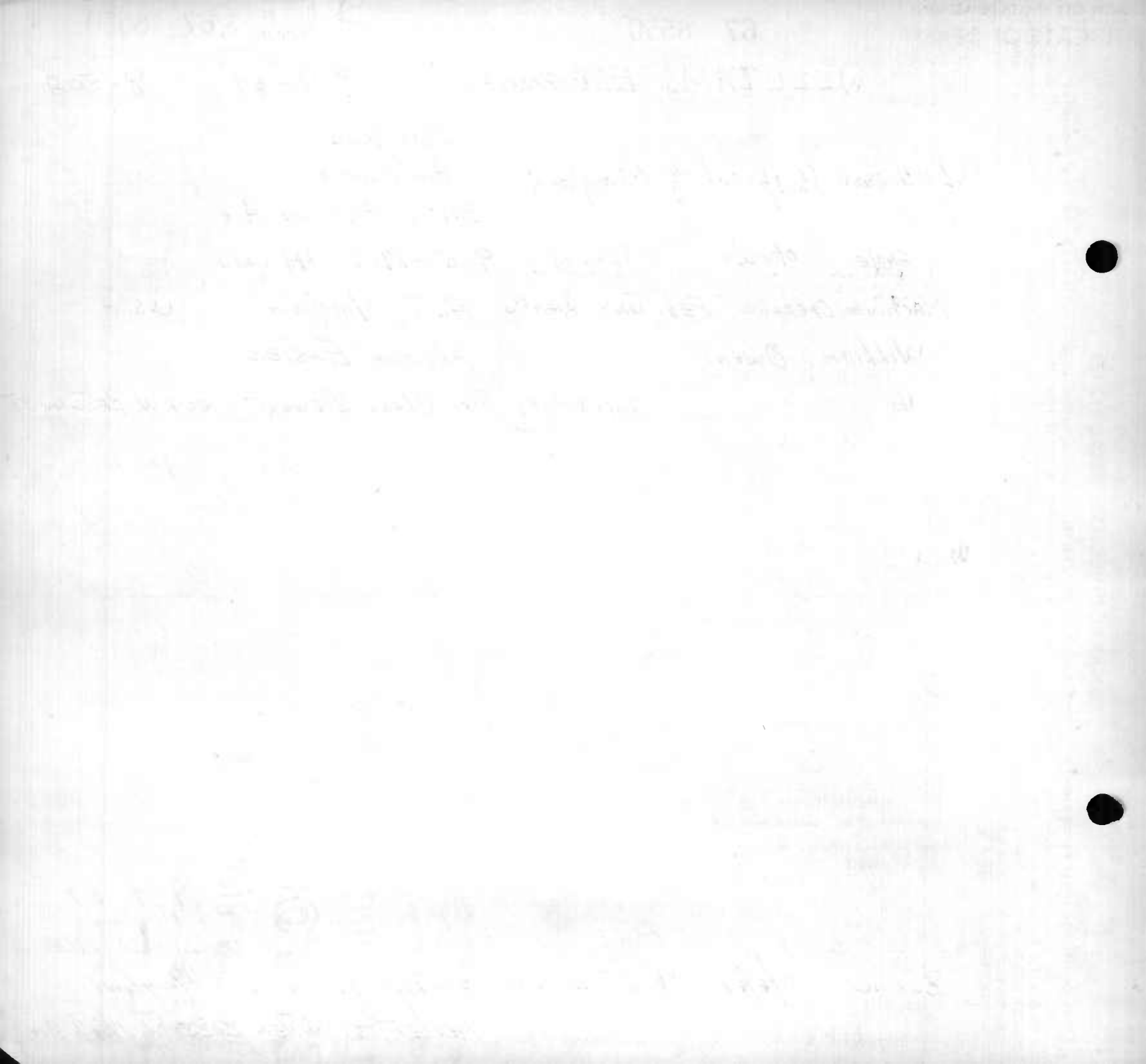
William Reese Annapolis

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8550	
BIRTH NO. 67 8550		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAMS, ELEANORA		2. DATE AND HOUR OF DEATH 9-1-67 8-50A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-05 D. STREET ADDRESS (If rural, give location) 2409 Arundel Ave.			
5. SEX FEMALE	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, MARRIED	8. DATE OF BIRTH 9-5-1917	9. AGE (In years last birthday) 49 years	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY FED. TINT PAPER CO.		11. BIRTHPLACE (State or foreign country) ANTI VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William OWENS		14. MOTHER'S MAIDEN NAME Alcinda EASTER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-9693		17. INFORMANT MRS. CLARA STEWART	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) C.V.A., Bacillary Artery DUE TO (B) Hypertension Haemorrhage DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 4-5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-1-1967 to 9-1-1967 , that (I) (we) last saw the deceased alive on 9-1-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-1-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI		23D. ADDRESS Lutheran Hospital of Maryland, 730 Ashmun St. Baltimore MD 21211			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/6/67		24C. NAME OF CEMETERY or CREMATORY MOUNT AUBURN CEMETERY	
24D. LOCATION BALTIMORE MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967			
25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR HERBERT E. NUTTER			
25D. ADDRESS 3035 W. North Ave					



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROY LAWSON

2. DATE AND HOUR PRONOUNCED DEAD

August 29, 1967

2:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2004 Edgewood Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept 26, 1936

9. AGE (In years
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Paper Hanger

10B. KIND OF BUSINESS OR INDUSTRY

Private Bus.

11. BIRTHPLACE (State or foreign country)

Roxboro, North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Joseph Lawson

14. MOTHER'S MAIDEN NAME

Gale Woody

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

218-32-0461

17. INFORMANT

ADDRESS

Mr. Joseph Lawson 2829 W. Cold Spring La

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)Bronchopneumonia complicating
cerebrocranial injuries(A)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2/ 8/2/67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Head injury

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3306 Walbrook Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8-2-67 3:10 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell from second floor porch

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 29, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/1/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Herbert E. Nutter 3035 W. North Ave

WALLER PRODUCE

SHOULD BE KEPT

WALLER PRODUCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8552		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8552	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Harry Paul Casimir Super (Superczynski)			2. DATE AND HOUR OF DEATH September 6th 1967 3:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3203 Howard Park Ave			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore, 7 C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-02 D. STREET ADDRESS (If rural, give location) 3203 Howard Park Ave		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/14/1892	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coppersmith		10B. KIND OF BUSINESS OR INDUSTRY Copperworks	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Super Superczynski			14. MOTHER'S MAIDEN NAME Julianna Lena Chelminski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-05-0751	17. INFORMANT Mr. Leroy Superczynski		
		ADDRESS 3203 Howard Park Ave			
18. 200.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Reticulum cell sarcoma DUE TO (B) Lymph nodes both inguinal (C) to abdominal cavity Metastases to liver		INTERVAL BETWEEN ONSET AND DEATH 1 year
19A. DATE OF OPERATION Sept 13, 1966			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ret. cell sarcoma		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Sept 8 1966 to Sept 6 1967 , that (I) (we) last saw the deceased alive on Sept 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE S.G. Sullivan			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-7-67
23C. PHYSICIAN'S NAME (Type) S.G. Sullivan			23D. ADDRESS M.D. 1129 St. Paul Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/9/67	24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR George A. Weber		25C. FUNERAL DIRECTOR George A. Weber	
				ADDRESS 705 South An n Street	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8553

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 8553									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) RALPH MC CASKILL					2. DATE AND HOUR PRONOUNCED DEAD September 2, 1967 4:50 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 726 Lennox Street				
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital					10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION WORK 11. BIRTHPLACE (State or foreign country) BETHUNE, S.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.				
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 8-19-1931		9. AGE (In years last birthday) 36	
13. FATHER'S NAME JESSE LEE McCASKILL					14. MOTHER'S MAIDEN NAME IANER BATS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 248-48-0085				
					17. INFORMANT ADDRESS Mrs. Ioner Bats Rte 2 Box 248 S.C.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E982X1 Stabwound of abdomen ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
INTERVAL BETWEEN ONSET AND DEATH									
19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 728 Lennox Street 13-02									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 9-2-67 3:00 P. 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Stabbed by unknown assailant									
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER DATE SIGNED September 3, 1967 EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER									
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 9-9-67 23C. NAME of CEMETERY or CREMATORY BETHUNE CEM. 23D. LOCATION (City, town, or county) (State) BETHUNE, SOUTH CAROLINA									
24A. DATE REC'D BY HEALTH DEPT. SEP 7 1967 24B. NAME OF REGISTRAR Robert E. Farley 24C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.									

WATERLOO FORMER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 67 8554		REGISTERED NO. 67 8554	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		DENKINS MARY L LOUISE		SEPTEMBER 4, 1967 9:50P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229		MARYLAND 21216			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
BALTIMORE		2620 W. LAFAYETTE ST. AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	COLORED	MARRIED	01-24-25	42	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		HOMEMAKER		NORTH CAROLINA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ARTHUR GIBBS			BEATRICE GEER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		237-28-2374		ST. AGNES RECORDS, CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		(D)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0		NO		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<input type="checkbox"/>	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 26, 1967 19 to SEPTEMBER 4, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPTEMBER 4, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Rafael Marin		9/4/67		9/4/67	
23C. PHYSICIAN'S NAME (Typed)		23D. ADDRESS			
RAFAEL MARIN, M.D.		WILKENS AND CATONS AVENUES BALTIMORE, MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		9-8-67		Baltimore National Cem. Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 7 1967		Rafael Marin		MORTON & DYETT F.H. 1701 Laurens St.	

SEPTEMBER 1, 1937

WIFE

WIFE

WIFE

BALTIMORE

ST. AGNES HOSPITAL
CATON & WILKINS AVES.
BALTIMORE, MD. 21229

2520 W. LAMAR AVENUE ST.

01-24-32

MARRIED

WIFE

U. S.

NORTH CAROLINA

HOMEMAKER

WIFE

WIFE

WIFE

ST. AGNES RECORDS, CATON & WILKINS AVES.

SEPTEMBER 1, 1937

JUNE 1, 1937

SEPTEMBER 1

XX

XX

X

WILKINS AND CATON AVENUES
BALTIMORE, MD. 21229

RAEEL WIFE, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
G-3501 67 8555					CERTIFICATE OF DEATH					Registered No. 67 8555									
BIRTH NO.										M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Rev. Thomas Godwin										2. DATE AND HOUR OF DEATH 9-4-67									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3522 CATON AVE.										A. STATE MD. B. COUNTY BALTO									
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO										20-67									
D. STREET ADDRESS (If rural, give location) 3522 CATON AVE.																			
5. SEX M		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 7-13-1913		9. AGE (In years lost birthday) 54		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister					10B. KIND OF BUSINESS OR INDUSTRY Church					11. BIRTHPLACE (State or foreign country) Fairmount, N.C.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Jerry Godwin										14. MOTHER'S MAIDEN NAME Martha Powell									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 227-05-0984					17. INFORMANT GRACE Goodwin					ADDRESS 3522 CATON				
18. 151X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hepatic Neoplasm DUE TO Juxta Carcinoma DUE TO 6 to 9 mos. ago.										INTERVAL BETWEEN ONSET AND DEATH as time of original diagnosis									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
II																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 9-10-67					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from Aug 1, '67 19 to Aug 10 19 67 , that (I) (we) lost saw the deceased alive on Aug 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.																			
23A. SIGNATURE Moses Paulson										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) Moses Paulson										23D. ADDRESS M.D. Eleven East Chase St. Balto Md 212									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 9-10-67					24C. NAME OF CEMETERY or CREMATORY Bridges Grove Ch. Cem. Fayetteville, N.C.					24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967					25B. NAME OF REGISTRAR Robert E. Taylor					25C. FUNERAL DIRECTOR MORTON Dyer					ADDRESS 1701 HARRIS				

3225 Latham Ave

2525 1st Ave

11-10-19

James Graham
Minister
Grace Church
11-10-19

3225 Latham Ave

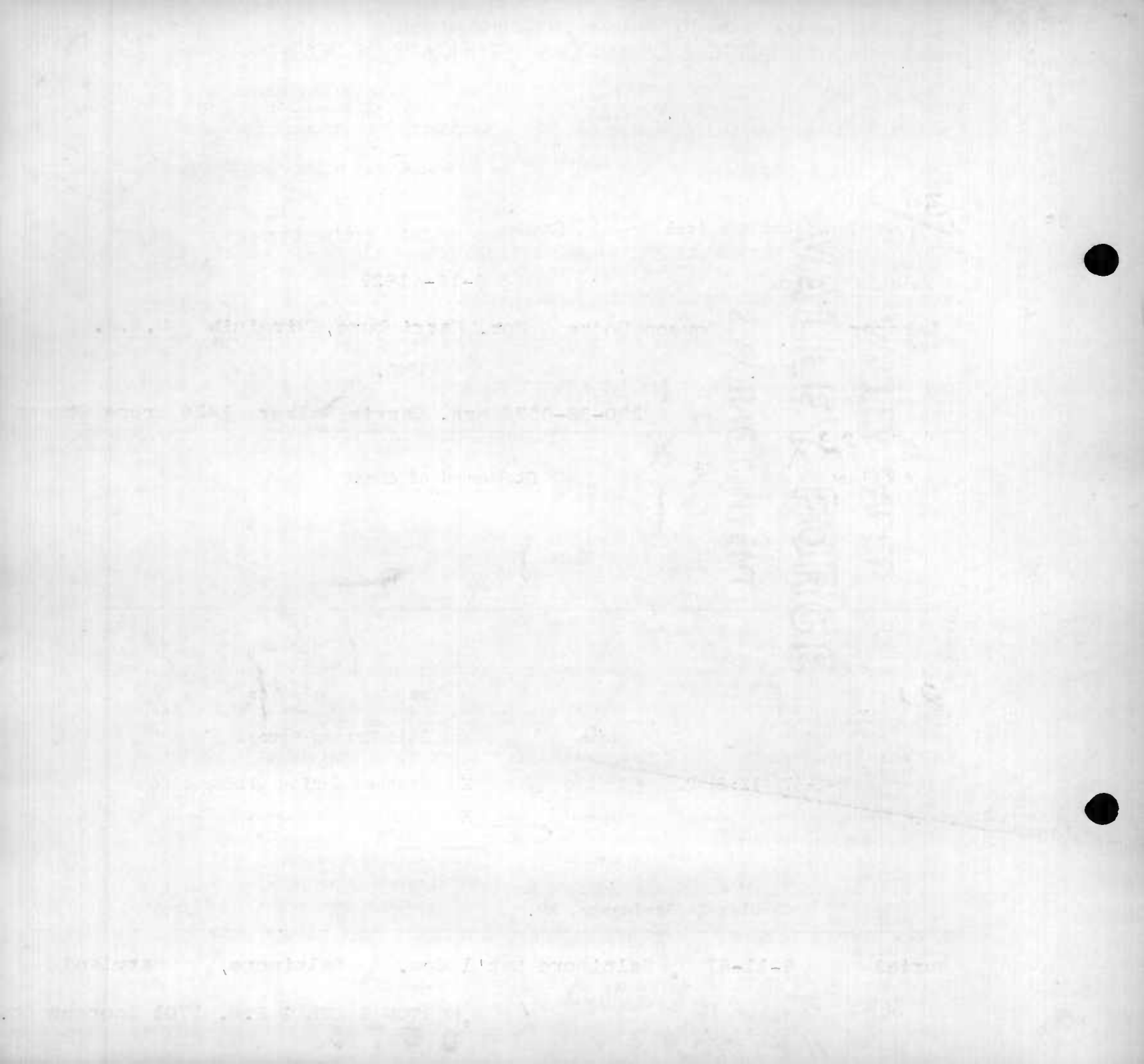
11-10-19

2525 1st Ave

James Graham
Minister
Grace Church
11-10-19

3225 Latham Ave

1		J-360 67 8556		BALTIMORE CITY HEALTH DEPARTMENT		67 8556	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
DANNY D. STARR				September 2, 1967 1:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
39/99 Provident Hospital (DOA)				Maryland			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				2415 Etting Street 13-03			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.		
Male	Negro		6-16-1922	45			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Towson Dodge & Mot.		Harrisburg, Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNK.				UNK.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		220-38-9574		Mrs. Carrie Walker 1420 Bruce Street			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, esthenia, etc. It means the disease, injury or complication which caused death.)				(A) Stabwound of chest			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
		home		2415 Etting Street 13-03			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Stabbed during altercation			
9-2-67 12:54 P.							
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Charles S. Springate, MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Springate, MD.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 3, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		9-11-67		Baltimore Nat'l Cem.		Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS			
SEP 7 1967 Robert E. Fink				MORTON & DYETT F.H. 1701 Laurens St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8557				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8557	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>EDNA J. CALLOWHILL</u>				2. DATE AND HOUR OF DEATH <u>Sept. 5, 1967</u> <u>7:45 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>34 BON SECOURS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>28-02</u> D. STREET ADDRESS (If rural, give location) <u>5206 FERN PARK AVE.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-17-91</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MARRIED</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>WITTE MAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>HAROLD S. CALLOWHILL - Same</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>420.01 Pulmonary edema</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) <u>2 days</u> (B) <u>1 wk.</u> (C) <u>years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 wk.</u> <u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cerebral arteriosclerosis</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 4</u> <u>1967</u> to <u>Sept 5</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 5</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date <u>Sept 5</u> <u>1967</u> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Cesar A. Bravo</u>					23B. DATE SIGNED <u>9/5/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>CESAR A. BRAVO</u>				23D. ADDRESS <u>Bon Secours Hospital.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-8-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1967</u>		25B. NAME OF REGISTRAR <u>Edith M. Taylor</u>		25C. FUNERAL DIRECTOR <u>Edwards Armacost</u>			
ADDRESS <u>4604 Liberty Hgts</u>							

WILLIAM BORDEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-08453 67 8558		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8558	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Johnny Howland</u>			2. DATE AND HOUR OF DEATH <u>9/2/67</u> <u>12:40 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital of Balt.</u>			A. STATE <u>Maryland</u> B. COUNTY <u>none</u>		
			C. CITY OR TOWN (If outside city limits, write JURAT and give township) <u>Baltimore</u> <u>27-18</u>		
			D. STREET ADDRESS (If rural, give location) <u>5237 Reisterstown Rd. 21215</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u>	8. DATE OF BIRTH <u>4/20/66</u>	9. AGE (In years last birthday) <u>1</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>child</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lionel Howland</u>			14. MOTHER'S MAIDEN NAME <u>Angela Pastore</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT ADDRESS <u>Parents</u> <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if only giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(A) <u>PENDING COMPLETION</u>		<u>✓</u>
			(B) <u>OF POST MORTEM</u>		<u>✓</u>
			(C) <u>MULTIPLE CONGENITAL ANOMALIES (INCLUDING ACHONDROPLASTIC DWARFISM) WITH SUDDEN DEATH DURING SEIZURE</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 2</u> 19 <u>67</u> to <u>Sept. 2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>never D.O.A.</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan J. Monfried</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>Alan J. Monfried</u>			23D. ADDRESS <u>Sinai Hospital of Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9-6-67</u>	24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairburn</u>		25C. FUNERAL DIRECTOR <u>Elsworth Armacost</u> ADDRESS <u>4601 Lib Hwy Ave</u>	

Pennington Corporation
Co. 1001 Thackeray

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

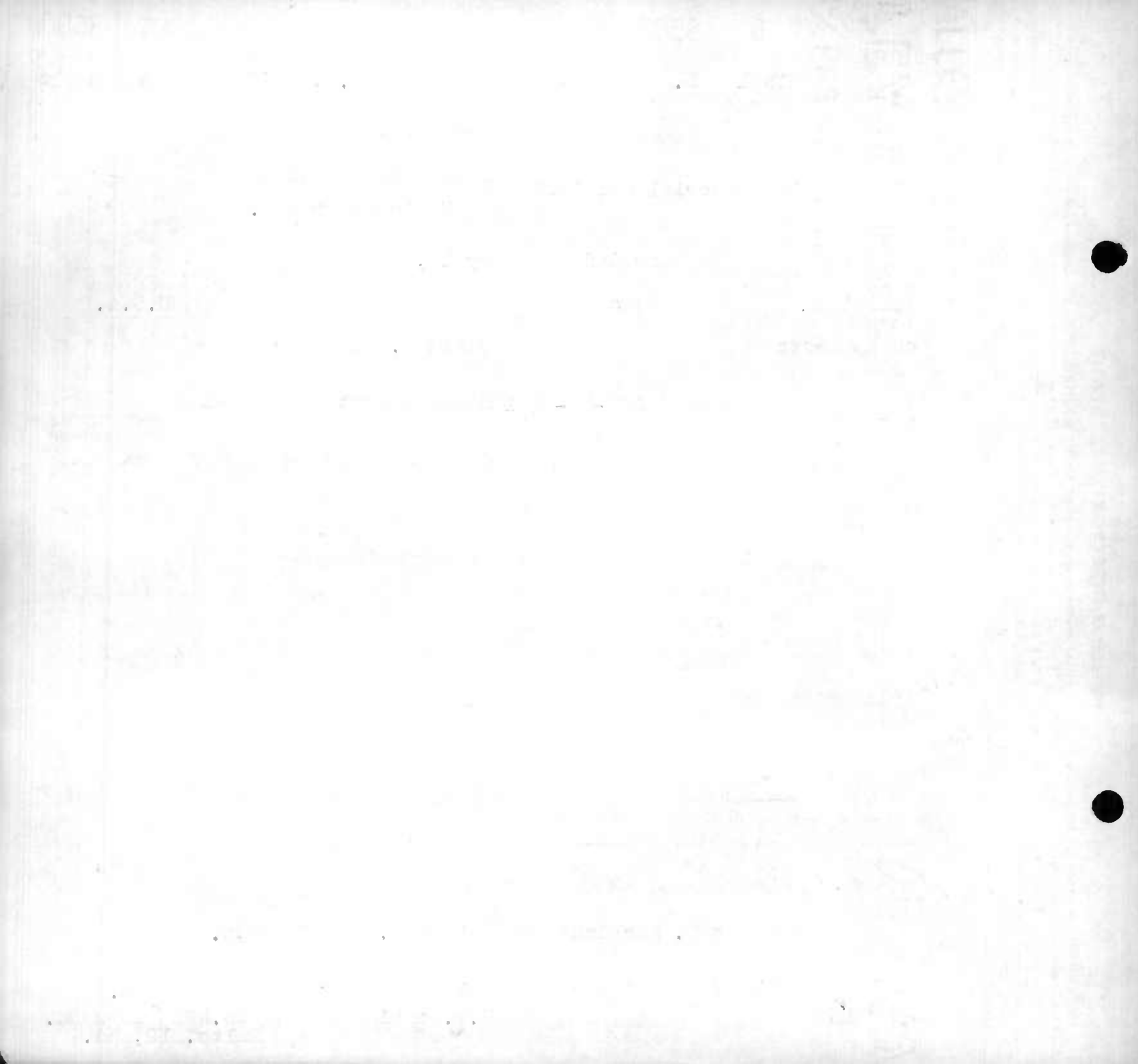
0-520		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8559	
BIRTH NO. 67 8559		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY J. OWENS		2. DATE AND HOUR OF DEATH Sept. 5, 1967. 245 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium 6116 Belair Road		A. STATE Md. 8. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3016 Woodside Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Feb. 20, 1896.	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry Kleinschmidt		14. MOTHER'S MAIDEN NAME Anna Kirchner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-9658		17. INFORMANT Mr. James A. Owens	
				ADDRESS (Same)	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Myocardial Cardiac Vascular Disease 20 yrs 2 Cerebral Vascular accident and Hemiplegia INTERVAL BETWEEN ONSET AND DEATH 6 Months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1947 to 9/5 1967 , that (I) (we) last saw the deceased alive on 8/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Thos. L. Worsley				23B. DATE SIGNED 9/6/67	
23C. PHYSICIAN'S NAME (Type) Thomas L. Worsley,		23D. ADDRESS M.D. 6505 York Rd., Baltimore, Md. 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/67.		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

VALLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> P-320 67 8560 BALTIMORE CITY HEALTH DEPARTMENT </div>		<div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH Registered No. 67 8560 </div>	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Ethel L. Potts		Sept. 6, 1967 2:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218 D. STREET ADDRESS (If rural, give location) 457 Ilchester Ave.	
44 Union Memorial Hospital		12-03	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 19, 1908
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 59
13. FATHER'S NAME Josiah Lentz		14. MOTHER'S MAIDEN NAME Susan M. Stricker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-8581	
		17. INFORMANT Michael Potts (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331 X I		CAUSE OF DEATH (A) Cerebrovascular accident DUE TO (B) Hypertension DUE TO (C) Arteriosclerosis	
INTERVAL BETWEEN ONSET AND DEATH minutes 10 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1948 to Sept 1 1967, that (I) (we) lost saw the deceased alive on Sept 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Charles C. MacMinn M.D.		23B. DATE SIGNED Sept 7, 1967	
23C. PHYSICIAN'S NAME (Type) Charles C. MacMinn M.D.		23D. ADDRESS 2900 E. Baltimore St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67	
24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto. 12, Md.	



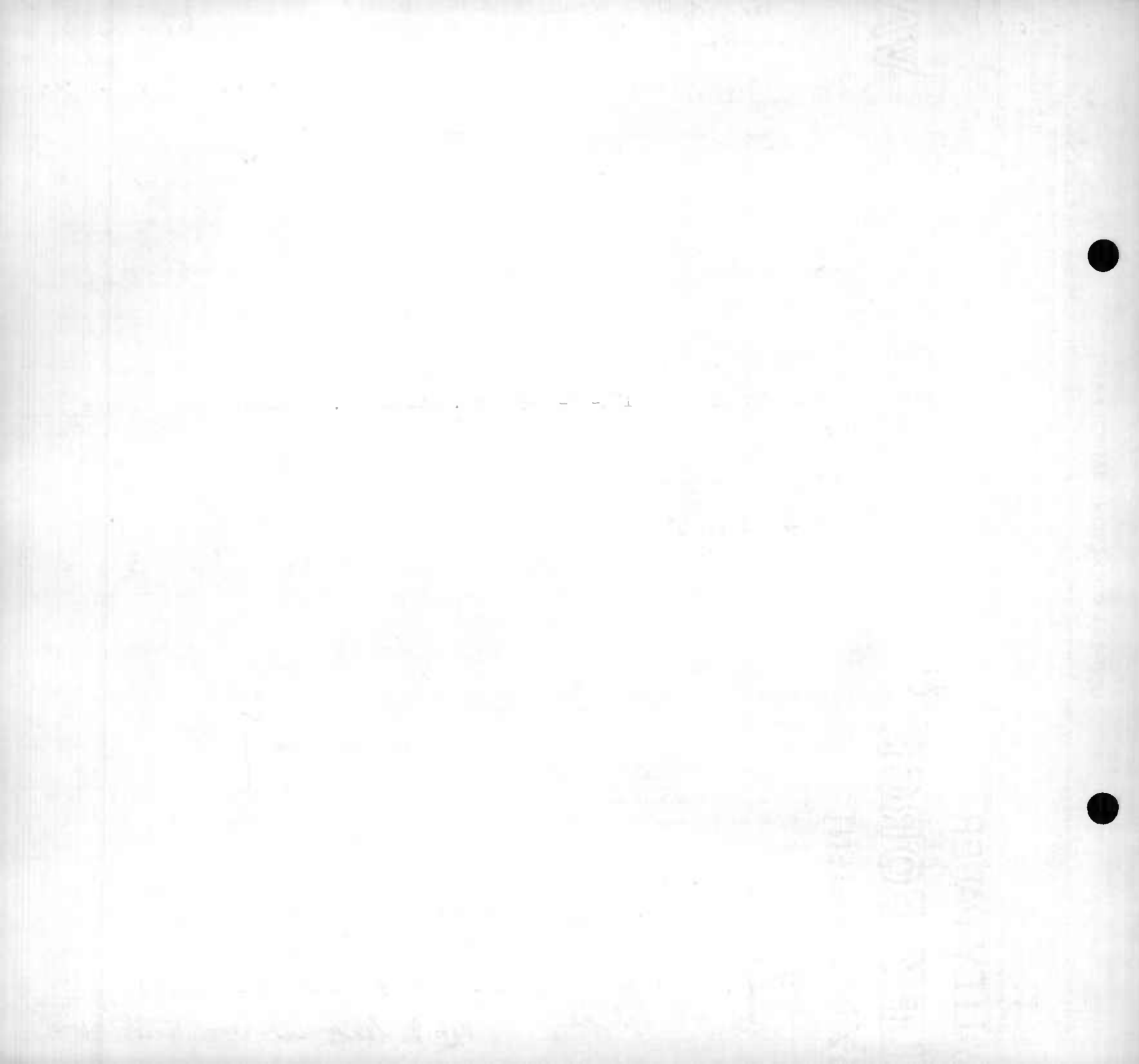
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>E-120 67 8561 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 67 8561</p>			
BIRTH NO. _____ M.E. CASE NO. _____ 1. NAME OF DECEASED (Type or Print) Harriet L. Ebaugh		2. DATE AND HOUR OF DEATH 8-31-67 4:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 719 Winans Way Baltimore, Maryland 21229		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 719 Winans Way 21229	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 9/17/1896
9. AGE (In years lost birthday) 70		If Under 1 Yr. Months _____ Days _____ If Under 24 Hrs. Hours _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Clerk		10B. KIND OF BUSINESS OR INDUSTRY B and O RR	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME George W. Ebaugh		14. MOTHER'S MAIDEN NAME Mary Disney Waugh	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Miss Lulu Ebaugh same address
18. 422.141 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular disease - DUE TO _____ (B) _____ DUE TO _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-17-1955 to 8-31-1967 , that (I) (we) last saw the deceased alive on 8-31-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Harry L. Knipp		23B. DATE SIGNED 9-1-67	
23C. PHYSICIAN'S NAME (Type) HARRY L. KNIPP		23D. ADDRESS 4116 Edmondson Ave. Balto. 29 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/2/67	
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Wm. J. Fickner	
25C. FUNERAL DIRECTOR Wm. J. Fickner		ADDRESS Balto. Md.	

Wm. F. Tuckman

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8562		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8562	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Mr. MacClure</i>			2. DATE AND HOUR OF DEATH <i>9-6-67 11:20 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>B. Maryland</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>13 E. Read St.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>10-10-05</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Engineer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Alabama</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Wm. A. MacClure</i>			14. MOTHER'S MAIDEN NAME <i>MARY Lynch</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War II</i>		16. SOCIAL SECURITY NO. <i>121-05-9553</i>		17. INFORMANT <i>Mrs. Lillian S. MacClure</i>	
				ADDRESS <i>same address</i>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Probable multiple pulmonary emboli</i> DUE TO (B) <i>Congestive heart failure</i> DUE TO (C) <i>Arteriosclerotic Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wtr.</i> <i>? years</i> <i>12+ years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-17</i> 19 <i>67</i> to <i>9-6</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9-6</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kenneth Stern</i>				23B. DATE SIGNED <i>9/6/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/11/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 7 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. F. Rickman</i>	
				ADDRESS <i>Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 8563		Registered No. 67 8563	
BIRTH NO.		67 8563		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Helen Meyer Greenbaum		2. DATE AND HOUR OF DEATH September 4, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, (if institution: residence before admission)) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address at location) 00 7301 Park Heights Ave. Baltimore, Maryland 21208		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-20 D. STREET ADDRESS (If rural, give location) 7301 Park Heights Ave. 21208			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12/18/1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Ike Meyer		14. MOTHER'S MAIDEN NAME Julia Good		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None	
16. SOCIAL SECURITY NO. 218-04-0255		17. INFORMANT Mr. Daniel Greenbaum		ADDRESS 7900 Long Meadow Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) 420.1 + IE 903.00 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. CAUSE OF DEATH (A) DUE TO Arteriosclerotic heart disease acute myocardial infarction fracture, lt elbow (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Minutes 10 hours	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) cleared by him		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Ingram Hall Apts - Balto-8-Md.	
21D. TIME OF INJURY (APPROX.) 9 3 67 8 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Tripped on telephone wire	
22. I certify that (I) (this hospital) attended the deceased from did not attend to that (I) (we) last saw the deceased alive and did not see alive and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Louis H Schaffer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/5/67	
23C. PHYSICIAN'S NAME (Type) Louis H Schaffer		23D. ADDRESS M.D. 222 W Wed Spring Lane, Baltimore, MD 21204			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/67		24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967			
25B. NAME OF REGISTRAR Robert E. 9 6 7 0 0		25C. FUNERAL DIRECTOR W. F. Rechner Sons			
25D. ADDRESS Balto, Md.		25E. ADDRESS Balto, Md.			

Cleared by medical examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				67 8564		Registered No. 67 8564	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EMMA B. CORNWALL				2. DATE AND HOUR OF DEATH 9-2-67 3:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY BALTO.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow				8. DATE OF BIRTH 9-13-91 9. AGE (In years lost birthday) 75			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PENNA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN BURKE				14. MOTHER'S MAIDEN NAME Karman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Unknown				16. SOCIAL SECURITY NO. ?			
17. INFORMANT MRS Cecelia JEFFREY				ADDRESS THWDAKISTOWN md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 23-7-1 I				CAUSE OF DEATH (A) Uremia (A) Subarachnoid hemorrhage, probable (B) Chronic pyelonephritis (C) polycystic kidneys (C) Uremia, 2° to Pyelonephritis, probable			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH ? 7 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ✓		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-1-67 19 to 9-2 19 67, that (I) (we) last saw the deceased alive on 9-2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frank Palmisano M.D.						23B. DATE SIGNED 9-2-67	
23C. PHYSICIAN'S NAME (Type) FRANK S. PALMISANO, JR.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 6 1967		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) 3310 Taylor Ave. Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. Lickner & Sons North Pa. Aves.			

EMMA B. CORNWALL

Union Memorial Hosp

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SOPHIA UNKNOWN

Mrs Cecilia Jeffrey

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Frank Robinson

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THE IN THE YEAR 1871

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-240		67 8565		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8565	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Herbert S. Michael				September 5, 1967 3 ³⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
90		Melchor Nursing Home 2327 N. Charles St.		Md.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 12-02			
				D. STREET ADDRESS (If rural, give location)			
				3217 N. Calvert St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days Hours Min.	
Male	White	Widowed		Jan. 21, 1881	86		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Oyster Packer (Retired)				Cincinnati, Ohio		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George W. Michael				Ada Stevenson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		219-20-8871		Mrs. Mary M. Brumfield 3231 St. Paul St.			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) <i>arteriosclerotic cardiovascular disease</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
				(B) _____ DUE TO			
				(C) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1967 to Sept 5 1967, that (I) (we) last saw the deceased alive on Sept 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Francis X. Carmody M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						Sept 7 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
FRANCIS X. CARMODY				M.D. 3201 N. CHARLES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Sept. 8, 1967		Woodlawn Cemetery		Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 7 1967		Robert E. Stoddy		Wm. F. Tickner & Sons		Baltimore, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-655		67 8586		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8586	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>FREEMAN, MARY H.</u>		2. DATE AND HOUR OF DEATH <u>SEPT 5, 1967 4 05 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp.</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		12-02	
D. STREET ADDRESS (If rural, give location) <u>1 E. UNIVERSITY PARKWAY</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>5/29/1874</u>	9. AGE (in years last birthday) <u>93</u>	II Under 1 Yr. Months Days		II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Travel Bureau</u>		11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN S. Lusk</u>				14. MOTHER'S MAIDEN NAME <u>M. Alice Freeman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss B. M. Heywood</u>		ADDRESS <u>205 Tyron Road</u>	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Acute bronchopneumonia</u> <u>ASVD & Congestive heart failure</u> (B) DUE TO (C) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>8/10/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GANGRENE OF R FOOT</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 19 <u>67</u> to <u>9/5</u> 19 <u>67</u> , that (I) was lost saw the deceased alive on <u>9/5</u> 19 <u>67</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.							
23A. SIGNATURE <u>W. H. Oehlert, Jr.</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/5/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. H. OEHLERT, JR.</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/8/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm. F. Dickman & Sons</u>		ADDRESS <u>Baltimore, Md.</u>	

FUNERAL DIRECTOR: IMPORTANT

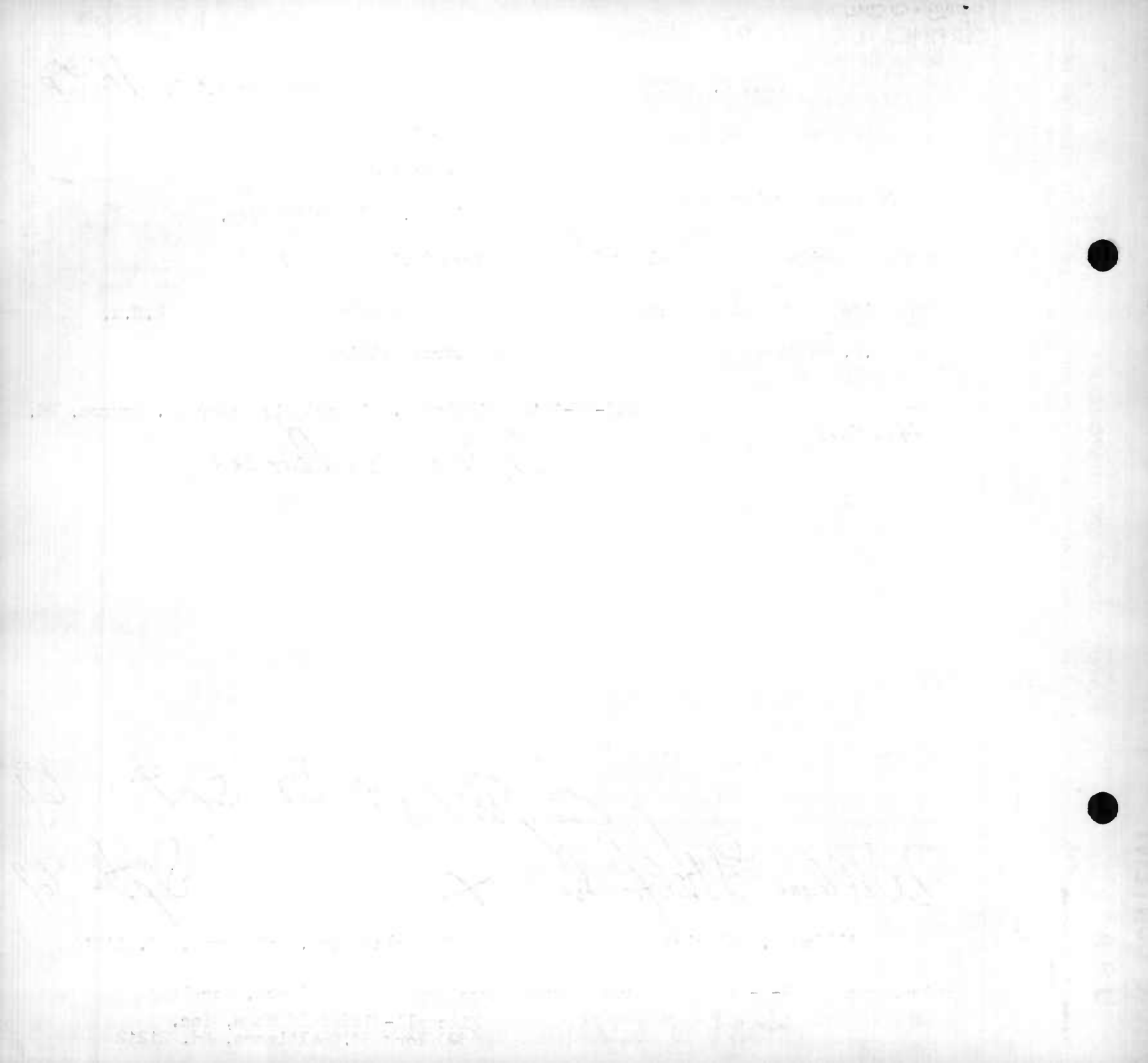
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-316		67 8567		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8567	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Florentine B. Sanford				Sept. 2, 1967 1:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Uplands Home 4501 Old Frederick Rd.				A. STATE Md. B. COUNTY Baltimore 28-04			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Nov. 4, 1878	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 88		11. BIRTHPLACE (State or foreign country) Montgomery County, Md.	
13. FATHER'S NAME John E. Buck				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-54-3182		14. MOTHER'S MAIDEN NAME Isabella Rizer	
17. INFORMANT Mrs. Idus Robertson				ADDRESS Uplands Home 4501 Old Frederick Rd.			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Anteroseptal Cardio-vascular disease DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 yr +	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Diverticulitis				1 month			
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from Aug 12 1967 to Sept 2 1967, that (I) (we) last saw the deceased alive on Aug 31 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE John A. Nesbitt Jr. M.D.				23B. DATE SIGNED 9-3-67		23C. PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 5, 1967		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) 3801 Frederick Rd. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Bryant Pickner & Sons, North & Pa. Aves.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-536 67 8568 BALTIMORE CITY HEALTH DEPARTMENT </div>		<div style="display: flex; justify-content: space-between;"> 67 8568 CERTIFICATE OF DEATH </div>		Registered No. 67 8568	
BIRTH NO. 67 8568 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JEAN M. SMITH			2. DATE AND HOUR OF DEATH September 3, 1967 1230 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 100 W. University Pkwy.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH March 14, 1878	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME B.P. Maguire			14. MOTHER'S MAIDEN NAME Sarah Mellinger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-1610	17. INFORMANT ADDRESS William F. Wingard 413 Range Rd. Towson, Md.		
18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Arteriosclerosis (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Aug 12 19 67 to Sept 6 19 67 . that (I) (we) lost saw the deceased alive on Aug 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William G. Helfrich			23B. DATE SIGNED Sept 4 '67		
23C. PHYSICIAN'S NAME (Type) William G. Helfrich			23D. ADDRESS 5006 Roland Ave. Baltimore, Md. 21210		
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 9-5-67	24C. NAME of CEMETERY or CREMATORY Green Mount Mausoleum		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT SEP 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 85691. NAME OF DECEASED
(Type or Print)

WILLIAM FREY

2. DATE AND HOUR PRONOUNCED DEAD

August 29, 1967 9:44 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

00 2303 Maryland Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2303 Maryland Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 24, 1912

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Radio and T. V. Repairman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William J. Frey

14. MOTHER'S MAIDEN NAME

Clara Kopf

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Groff Funeral Home Lancaster, Pa.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 29, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

8/30/67

23C. NAME of CEMETERY or CREMATORY

Greenwood Cemetery

23D. LOCATION

(City, town, or county)

(State)

Lancaster, Pa.

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Wm. F. Zickner & Sons Baltimore, Md.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MATILDA BELL

2. DATE AND HOUR PRONOUNCED DEAD

September 2, 1967 1:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Virginia

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Bedford

D. STREET ADDRESS (If rural, give location)

1732 Longwood Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 26, 1906

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Marshall Sledd

14. MOTHER'S MAIDEN NAME

Elizabeth Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Oswald G. Smith 1938 Bunker Hill Rd., NE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hypertensive cardiovascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S
NAME (Type)ASSOCIATE MEDICAL EXAMINER ☐

September 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sep-9-1967

23C. NAME of CEMETERY or CREMATORY

Longwood Cemetery

23D. LOCATION

(City, town, or county)

(State)

Bedford, Virginia

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1967

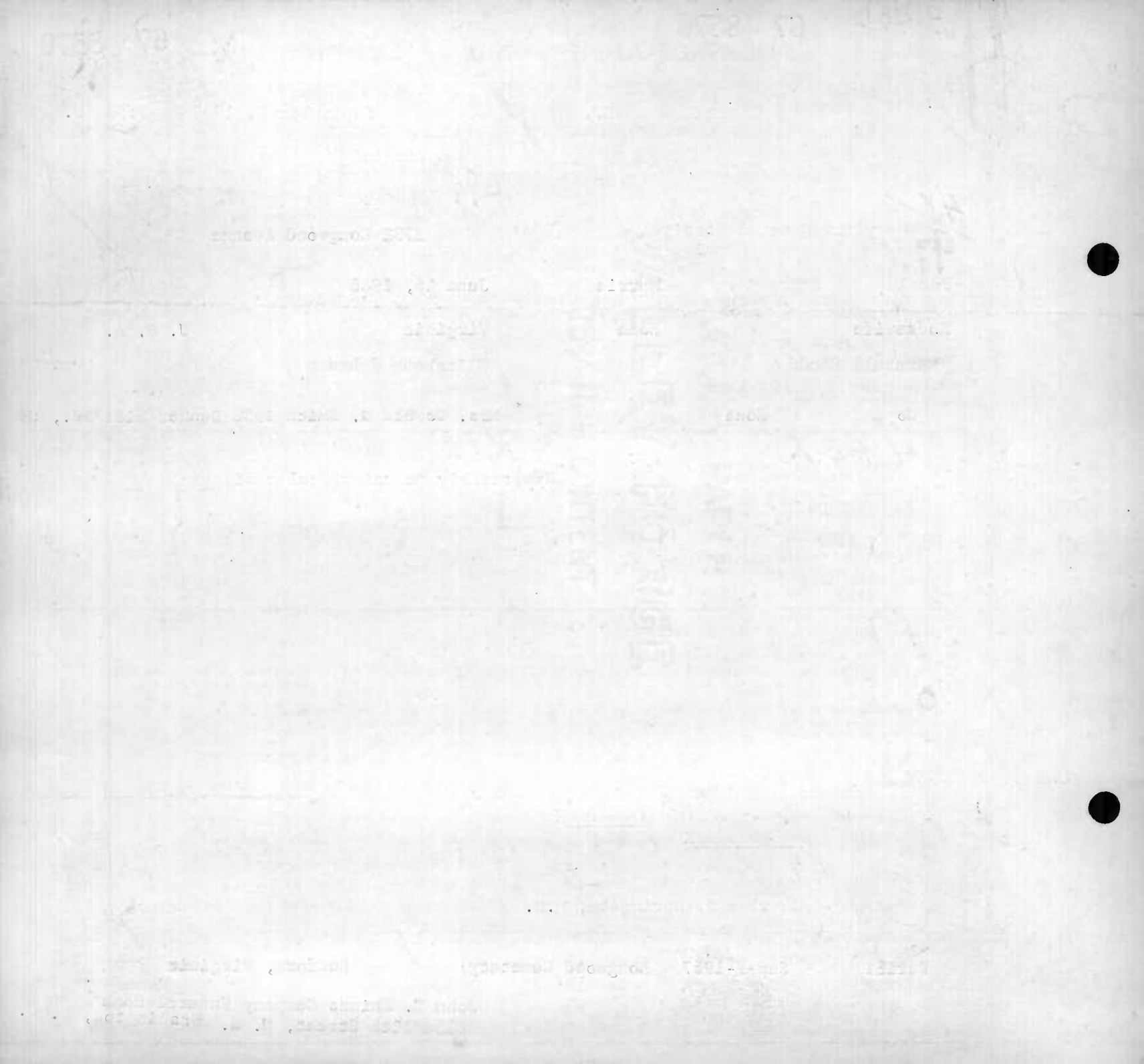
24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

ADDRESS

John T. Rhines Company Funeral Home
3015 12th Street, N. E. Washington, D. C.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8571 CERTIFICATE OF DEATH					Registered No. 67 8571				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Strasser, Blanche E.</i>					2. DATE AND HOUR OF DEATH <i>9/6/67 1:30 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp.</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
D. STREET ADDRESS (If rural, give location) <i>409 East Lorraine Avenue</i>					12-03				
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>3/19/95</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Robert B. Strasser Colbert</i>					14. MOTHER'S MAIDEN NAME <i>Kate Callahan</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>705 05 6672-B</i>		17. INFORMANT <i>ANDREW F. STRASSER (same)</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <i>201X I Hemorrhagic congestion, edema</i> <i>(A) Respiratory failure</i> <i>(B) Metastatic Tumor</i> <i>(C) Metastases</i>					INTERVAL BETWEEN ONSET AND DEATH <i>March 1967</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>8/30/67</i> to <i>9/6/67</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>9/6/67</i> and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above (I) (<i>we</i>) (<i>did</i>) (<i>did not</i>) view the body after death.									
23A. SIGNATURE <i>H. F. Holcomb</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/6/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>H. F. Holcomb</i>					23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL 322 Stensson Lane, Towson</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<i>Burial</i>		<i>9/8/1967</i>		<i>Baltimore</i>		<i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 7 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co.</i>				
					ADDRESS <i>4905 York Rd Balto. 12, Md.</i>				

Wash. Amaria / Sep. 24/1900

Not a student

2/10/22 25

14

~~James C. [illegible]~~ 10/10/10

70202 0815

W. H. C. C. C.

THE UNITED STATES OF AMERICA

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8572 CERTIFICATE OF DEATH					Registered No. 67 8572				
BIRTH NO. M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) BLANK JOSEPH FRANCIS					SEPTEMBER 5 1967 12:30A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL CATON & WILKENS AVE BALTO 21229 MD 40 9-19-67					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21227 MD 53-00 D. STREET ADDRESS (If rural, give location) 3605 ANNAPOLIS RD				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 03/19/93	9. AGE (In years last birthday) 74	II Under 1 Yr. Months Days		II Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR			10B. KIND OF BUSINESS OR INDUSTRY BUILDER		11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME LOUIS BLANK					14. MOTHER'S MAIDEN NAME MARIE-MYUELNER Milner				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes NO WW 1 1918			16. SOCIAL SECURITY NO. 212-28-8323		17. INFORMANT ADDRESS ADMISSION SLIP -ST AGNES HOSP.				
18. 20401 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) LIMPHOCYTIC LEUKEMIA DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 19 19 67 to SEPTEMBER 5 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPT 5 19 67 and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.									
23A. SIGNATURE <i>G. Braun</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED SEPTEMBER 5 1967		
23C. PHYSICIAN'S NAME (Type) G. Braun		23D. ADDRESS M.D. St. Agnes Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1967		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229					

FUNERAL DIRECTOR: IMPORTANT

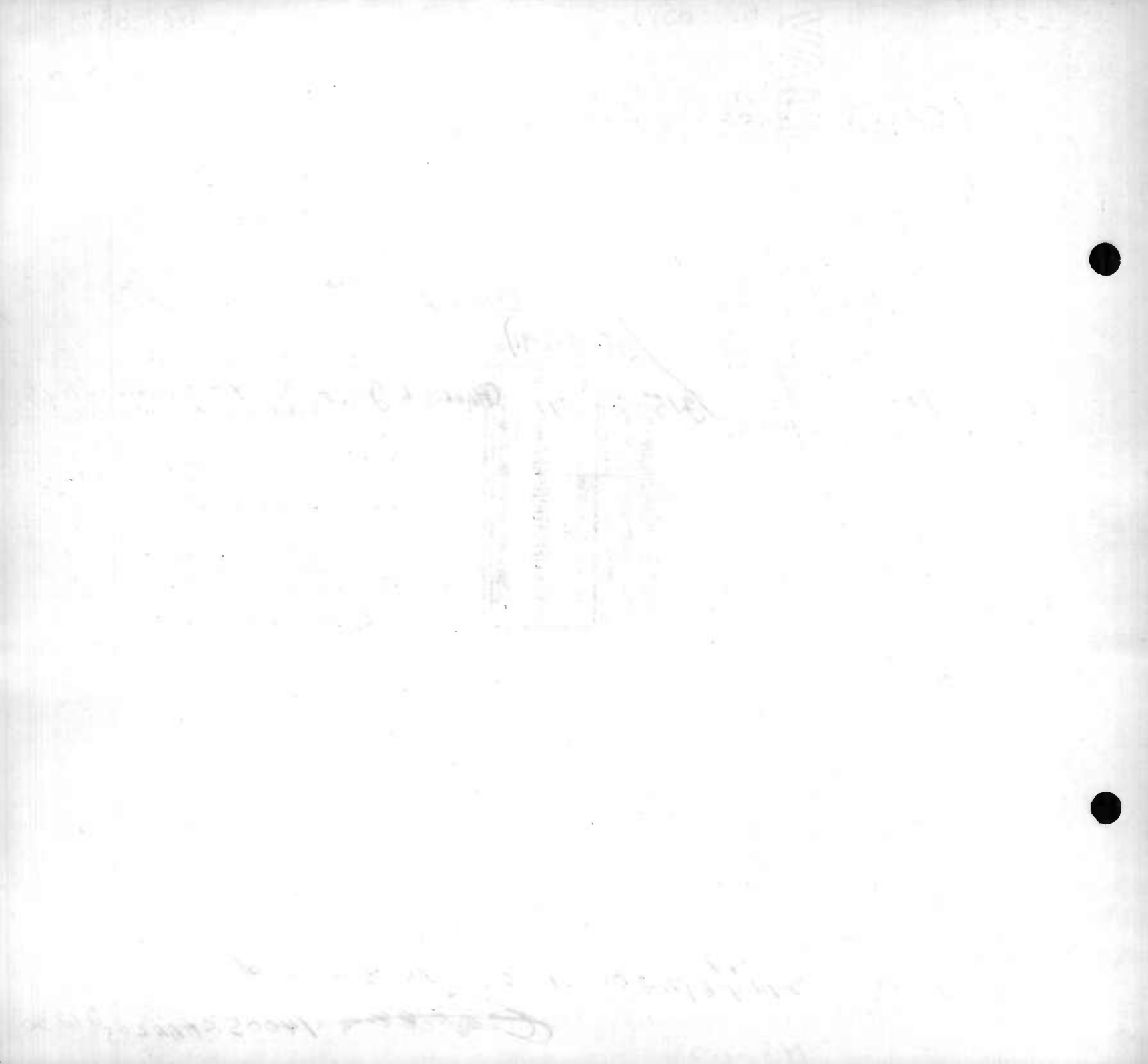
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8573		67 8573		67 8573	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		MARY THOMPSON		9/1/67 10 ³⁰ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
380 UNIVERSITY OF MARYLAND HOSPITAL		(LAUREL) MARYLAND			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		LAUREL		Howard Co.	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
F		N		MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
				4/4/06	
				9. AGE (In years last birthday)	
				61	
				11. BIRTHPLACE (State or foreign country)	
				MARYLAND	
				12. CITIZEN OF WHAT COUNTRY?	
				USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				HUSA AND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) ACUTE MYOCARDIAL INFARCTION		3 DAYS	
ANTECEDENT CAUSES		(B) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE		YRS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that this (this hospital) attended the deceased from		8/28 1967 to		Sept 1 1967.	
that we (we) last saw the deceased alive on		9/1 1967		and that in my (our) opinion death occurred on the date	
and hour and from the causes stated above. (We) (We) (did) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Ray Plotnick				9/1/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		Sept. 6 1967		Mt. Zion Cemetery	
				Bacantown, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 7 1967		Robert E. [unclear]		Robert E. Snowden Rockville, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8574		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8574	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>CARRIE DIETZ</i> (CAROLINE)			2. DATE AND HOUR OF DEATH <i>9-6-67 1:40 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>CARRIE CAROLINE DIETZ</i> <i>South Baltimore General Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>23</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230</i> D. STREET ADDRESS (If rural, give location) <i>1305 S. HANOVER ST.</i>		
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>3/22/95</i>	9. AGE (In years last birthday) <i>72</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed at home Retired.</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Queen Anne's Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>
13. FATHER'S NAME <i>PETER H. RETH 215-38-2911</i>			14. MOTHER'S MAIDEN NAME <i>FANNY C. HIGDON</i>		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>215-38-2911</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>443X + E904.0</i>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		
17. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			20. MEDICAL CERTIFICATION FOR THE PERSONAL USE OF ATTENDING PHYSICIAN NOT FOR HOSPITAL OR OTHER OFFICIAL USE CERTIFICATION APPROVED BY M.D. <i>Abdul G. Zureshi</i>		
19A. DATE OF OPERATION <i>9-5-67</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fr. Rt. Femur</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>10 AM 9-6-67</i>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>1305 SOUTH HANOVER ST.</i>			21F. HOW DID INJURY OCCUR? <i>Fell at home</i>		
22. I certify that (if) (this hospital) attended the deceased from <i>8-16-67</i> to <i>9-6-67</i> , that (if) (we) last saw the deceased alive on <i>9/6</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			20A. AUTOPSY? (Yes or No) <i>YES</i>		
23A. SIGNATURE <i>Quinn</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>		
23B. DATE SIGNED <i>9/6/67</i>			23C. PHYSICIAN'S NAME (Type) <i>Abdul G. Zureshi</i>		
23D. ADDRESS <i>1213 Light Street</i>			23E. M.D. <i>Abdul G. Zureshi</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>Sept 9-67</i>		
24C. NAME of CEMETERY or CREMATORY <i>Mount Olivet Cem</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 8 1967</i>			25B. NAME OF REGISTRAR <i>Abdul G. Zureshi</i>		
25C. FUNERAL DIRECTOR <i>CURTIS E. EVANS</i>			25D. ADDRESS <i>1400 S. CHARLES ST 21230</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8575		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8575	
M.E. CASE NO.		CERTIFICATE OF DEATH		10-10-67	
1. NAME OF DECEASED (Type or Print) HOOD IDA VIOLET		2. DATE AND HOUR OF DEATH 9-4-67		10-10-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Howard Co		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ellicott City 63-00	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) Church Rd.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 08-23-96	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES YATES		14. MOTHER'S MAIDEN NAME NANNIE THORPE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 07 8922		17. INFORMANT ADDRESS Mrs Irvin Gladding Church Rd, Ellicott City	
18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage Encephalomalacia (B) DUE TO (C) DUE TO		INTERNAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-4-67 to 9-4-67, that (I) (we) last saw the deceased alive on 9-4-67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raul V. Desquitado		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-4-67	
23C. PHYSICIAN'S NAME (Type) RAUL V DESQUITADO		23D. ADDRESS THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 9/6/67		24C. NAME OF CEMETERY or CREMATORY St. John	
24D. LOCATION Ellicott City, Md.		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Highsmith, Slack	
				ADDRESS Ellicott City, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8576	
BIRTH NO. 67 8576		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Aino Johnson		2. DATE AND HOUR OF DEATH Sept. 6, 1967 6 ³⁰ A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bel Aire House In The Pines 5837 Belair Rd.		A. STATE Maryland B. COUNTY Baltimore Co.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) White Marsh 53-00			
		D. STREET ADDRESS (If rural, give location) 596 Larch Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 11/22/95	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman		10B. KIND OF BUSINESS OR INDUSTRY Pemco Corp.		11. BIRTHPLACE (State or foreign country) Finland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Justus Gohlstrand			
14. MOTHER'S MAIDEN NAME Mathilda Sahalahden		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 092-10-4754		17. INFORMANT (Daughter) Md. ADDRESS 21162 Mrs. Helen Dameron, 596 Larch Rd. White Marsh			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gastric Ulcer		CAUSE OF DEATH (A) <i>Atellectatic Pneumonia</i> DUE TO (B) <i>Chronic Brain Syndrome</i> DUE TO (C) <i>Ante-mortem Cerebral Death</i>		INTERVAL BETWEEN ONSET AND DEATH 3 days. 71 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/5/67 11/10/67 to 9/6/67 1967, that (I) (was) last saw the deceased alive on 9/5/67 1967 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i>				23B. DATE SIGNED 9/6/67	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley				23D. ADDRESS M.D. 4900 Belair Rd. Balto. Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/67		24C. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			

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Return
Gus W.

1/1/10
1/1/10
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Mr. O. S. S.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8577 BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				Registered No. 67 8577			
1. NAME OF DECEASED John Joseph Dudley								2. DATE AND HOUR OF DEATH 9/1/67 4:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hospital								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 404 Cambria Street			
5. SEX Male		6. RACE Cauc.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Feb 18, 1884		9. AGE (In years last birthday) 83		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker				10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orlando Dudley						14. MOTHER'S MAIDEN NAME Katherine Bissert					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-05-2872		17. INFORMANT Mrs Irene Dudley				ADDRESS 404 C ambria Street Baltimore, Md 21225	
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Cardiac Failure								CAUSE OF DEATH (A) DUE TO Arteriosclerosis (B) DUE TO Pericarditis Anemia (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 21 19 67 to Sept 1 19 67 , that (I) (we) last saw the deceased alive on Sept 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Louis J. Glass								M.D. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/2/67	
23C. PHYSICIAN'S NAME (Type) Louis J. GLASS								23D. ADDRESS M.D. 320 E. Patapsco Ave Balto 25, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 5, 1967		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park				24D. LOCATION (City, town, or county) (State) Route #1 Howard Co, Maryland			
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967				25B. NAME OF REGISTRAR Robert E. [Signature]				25C. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hgwy, Balto, Md			

Electrocardiogram
Interpretation
Normal

Left Bundle Branch Block
Right Bundle Branch Block
ST-T changes
Normal

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8578		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8578	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FUTTY, CHARLES ELWOOD		2. DATE AND HOUR OF DEATH SEPT. 5, 1967 11:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Harford Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) JOPPA 62-00	
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL 100 N. CALHOUN ST. BALTIMORE, MARYLAND		D. STREET ADDRESS (If rural, give location) 706 MAGNOLIA ROAD			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-16-12	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHATELAIN		10B. KIND OF BUSINESS OR INDUSTRY Trucking company		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WINFIELD FUTTY		14. MOTHER'S MAIDEN NAME BERTHA PRYOR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 198-03-8988		17. INFORMANT ADDRESS FRANKLIN SQUARE HOSPITAL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Septicemic shock (?) - 24 hours		(A) DUE TO Pneumonia (?)		INTERVAL BETWEEN ONSET AND DEATH - 21 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) DUE TO Lung, Ca (?)			
(C) Lung, Ca (?)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 9-1-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 15 19 67 to Sept. 5 19 67 , that (I) (we) last saw the deceased alive on Sept. 5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruben V. Luna M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9-5-67	
23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNA		23D. ADDRESS 100 N. CALHOUN ST. BALTIMORE, M.D.A. ?			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 9, 1967		24C. NAME OF CEMETERY or CREMATORY Harts Union Methodist Cemetery, Elk Neck Cecil Md	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Howard K. McGomas & Son, Abingdon, Md					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8579 CERTIFICATE OF DEATH					Registered No. 67 8579				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) CHARLES H. COULSON					2. DATE AND HOUR OF DEATH 9/4/67 6:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY York				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSP.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) HANOVER				
					D. STREET ADDRESS (If rural, give location) 14 FOURTH STREET				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-23-91	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. Coulson Heel & Inner Sole Co.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) York County, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN COULSON					14. MOTHER'S MAIDEN NAME Elmira Herman				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 205-22-4333		17. INFORMANT Lillian A. Lau Coulson ADDRESS 14 Fourth St. Hanover, Pa.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 260X I					CAUSE OF DEATH (A) Pseudobulbar palsy, cardiac + resp. arrest. (B) cerebrovascular accident (C) Diabetes Mellitus + arteriosclerosis 17 yrs.				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH ~3-4 wks				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/1 19 67 to 9/4 19 67 , that (I) (we) lost saw the deceased alive on 9/4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Paul E. Nicholson					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9/4/67	
23C. PHYSICIAN'S NAME (Type) PAUL E. NICHELSON					23D. ADDRESS JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 9/4/67		24C. NAME of CEMETERY or CREMATORY East Berlin Cemetery			24D. LOCATION (City, town, or county) (State) East Berlin, Pa.		
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967			25B. NAME OF REGISTRAR Robert E. Fisher			25C. FUNERAL DIRECTOR John F. Fisher			

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Paul E. Paul

PAUL E. PAUL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8580				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8580	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				TUCKER, NORVELL D. SR.		9-5-67 7:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
44 UNION MEMORIAL HOSPITAL				MARYLAND		Balt. Co.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE		53-00	
				D. STREET ADDRESS (If rural, give location)			
				181 NEWBURG AVE.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
M		W		MARRIED		12-08-95	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED		NONE		MARYLAND VA.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN W. TUCKER				SALLY ANNA TUCKER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				213 18 3311		HOSP. REC.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		7 hours	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
				Cerebral Hemorrhage			
				Arteriosclerotic Vascular Disease			
				Pneumonia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9-4 19 67 to 9-5 19 67, that (I) (we) lost saw the deceased alive on 9-5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
DR. RAUL DESQUITADO						9-5-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RAUL DESQUITADO				THE UNION MEMORIAL HOSPITAL			
				M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9/8/67		ST. Johns		Ellicott City Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
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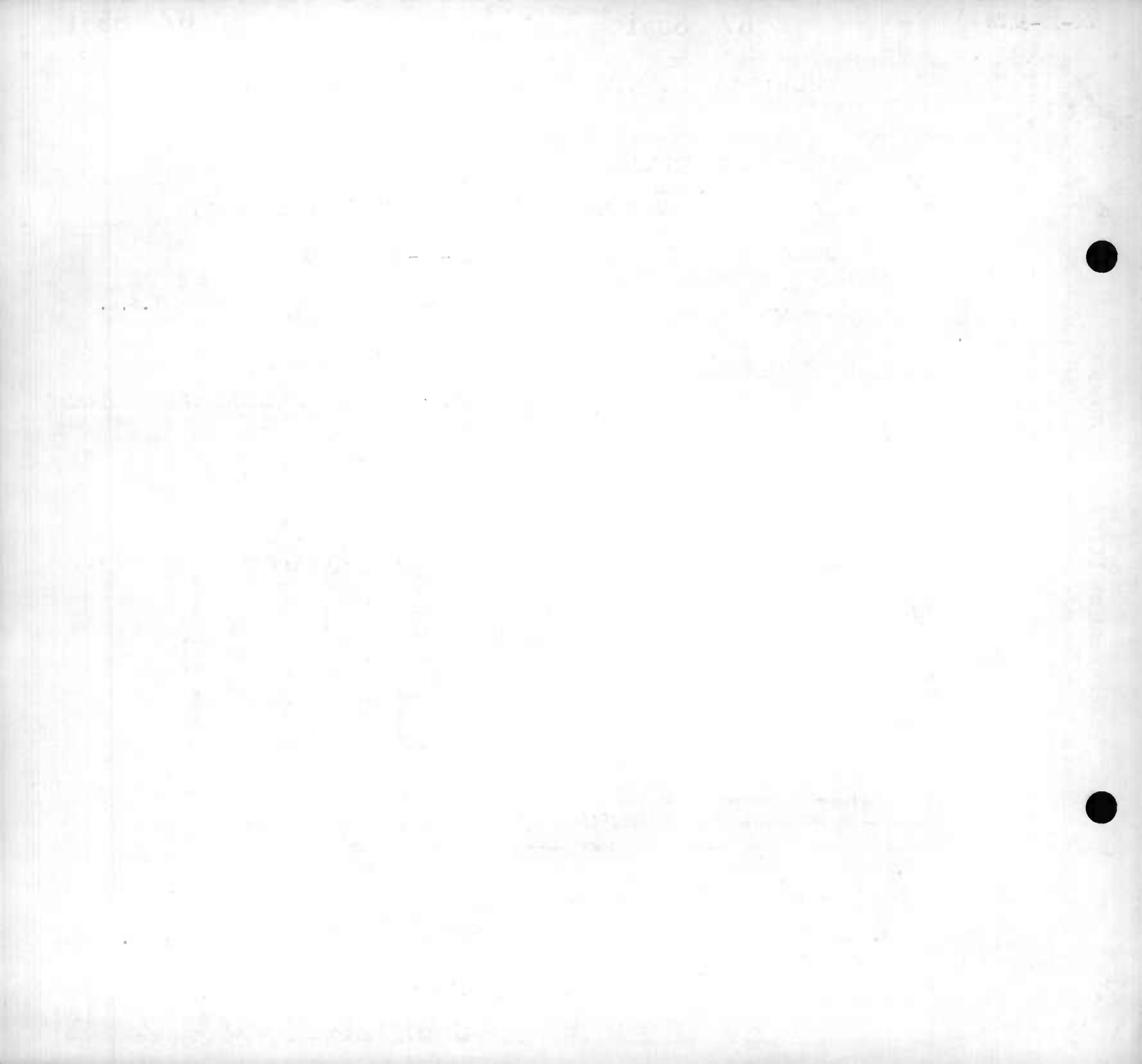
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40-13-54TH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. V-250		67 8581		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8581	
M.E. CASE NO.				BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) WILLIAM E. VAUGHN				2. DATE AND HOUR OF DEATH SEPTEMBER 7, 1967 12:41 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND B. COUNTY			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 1723 AIKEN STREET 21213			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 11-27-95	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-5246		17. INFORMANT ADDRESS BCR:RECORDS 4940 EASTERN AVENUE 21224			
18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gram negative Sepsis UTI (pyelonephritis) OBSTRUCTIVE UROPATHY				INTERVAL BETWEEN ONSET AND DEATH 8 days ? 4 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ca of Prostate							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from August 31 1967 to Sept. 8 1967 , that (H) (we) last saw the deceased alive on Sept. 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Raymond J. LaSure M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/7/67	
23C. PHYSICIAN'S NAME (Type) DR. RAYMOND LA SURE				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-67		24C. NAME OF CEMETERY OR CREMATORY not Auburn Cmt		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR John E. LaSure		25C. FUNERAL DIRECTOR Raymond J. LaSure		ADDRESS 1001 Brimley Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE RELEASED ON APPROVAL BY DR. KORNBLUM OF THE MEDICAL EXAMINER'S OFFICE

BIRTH NO. 67 8582		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8582	
M.E. CASE NO. NAME OF DECEASED (Type or Print) MARY GREGG			2. DATE AND HOUR OF DEATH 9-6-67 4:45AM M.		
PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1805 NORTH CAROLINE STREET		
SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-6-21	9. AGE (In years lost birthday) 46	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME PEYTON CALLAHAN			14. MOTHER'S MAIDEN NAME VIRGINIA FERGUSON		17. INFORMANT Kate Gregg ADDRESS same
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. M.D.		
18. 434.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) ? RIGHT HEART FAILURE DUE TO (B) ? of SEPSIS / ? of MULTIPLE SMALL PULMONARY EMBOLI DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-6-67 to 9-6-67 and that (I) (we) last saw the deceased alive on 9-6-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Michael Vincent M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9-6-67		
23C. PHYSICIAN'S NAME (Type) G. MICHAEL VINCENT M.D.			23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Crest	
24D. LOCATION same		24E. CITY, town, or county Md		24F. STATE Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR R. E. E. Taylor		25C. FUNERAL DIRECTOR Shay Wilson ADDRESS 1000 Branch St	

10/10/19

A. Michael Vincent

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 8583

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAVID COOK

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1967 8:47 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

723 E. Preston Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 24 1943

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

John

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James B. Cook

14. MOTHER'S MAIDEN NAME

Kathleen Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

James B. Cook

ADDRESS

Same

18. E 981X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Truck

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

500 block of E. North Ave. 9-08

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9 5 67 8:30 p.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Subject was shot

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 6, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-9-67

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 8 1967

R. E. Fisher, M.D.

Clayton Wilson 1000 Grand Ave

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

Office

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-5220		67 8584		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8584	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LILLIAN E. JONES				SEPTEMBER 6, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 Gould Nursing Home 6115 Belair Road				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				1713 North Washington Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
F	W	Widow	March 27, 1885	82			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		at Home		Baltimore Maryland		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Schmidt				Katherine Geiss			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		213 01 8097		Miss Anna M. Schmidt		1713 N. Wash. S	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Generalized Arteriosclerosis			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) Diabetes Mellitus			
ANTECEDENT CAUSES				(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				5 years			
				7 years			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (did) attended the deceased from 1960 to Sept. 1967, that (I) last saw the deceased alive on Sept. 5, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Loy M. Zimmermann						9/7/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Loy Zimmermann		M.D. 3202 Harford Road					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/9/67		Baltimore Cemetery		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 8 1967		Robert E. Taylor		HENRY SANDER & SONS INC.			
				BALTIMORE MARYLAND 21213			

15-10-1904



15-10-1904

15-10-1904

15-10-1904

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Certificate of Death		Registered No. 67 8585	
BIRTH NO. 67 8585		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EVERETT ALEXANDER FERRELL		2. DATE AND HOUR OF DEATH 9-7-67 10:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				4. USUAL RESIDENCE (Where deceased lived, (if institution: residence before admission) A. STATE MARYLAND B. COUNTY 4-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 411 PARK AVENUE			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July-12-1890		9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired) OWNER		10B. KIND OF BUSINESS OR INDUSTRY Gordshell Chem. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSHUA FERRELL			14. MOTHER'S MAIDEN NAME NOT KNOWN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-07-2169		17. INFORMANT A. P. Brightman-910-S-Central			
				ADDRESS Av-Clayton-5-Mo			
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UCI BLAD STRESS ULCER		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PNEUMONIA		2 WEEKS			
		(C) CHRONIC LUNG DISEASE		15 YRS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cor Pulmonale + CHF		1 yr			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (the hospital) attended the deceased from 8-22 19 67 to 9-7 19 67 , that (I) last saw the deceased alive on 9-7 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Major W. Bradshaw						23B. DATE SIGNED 9-7-67	
23C. PHYSICIAN'S NAME (Type) MAJOR W. BRADSHAW				23D. ADDRESS JOHNS HOPKINS BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE Sept-9-1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md. 21229	
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Stewart & Bowen Co-108-W-North-Av. 21201			

UCI Area Studies Center 6 Davis

2500

~~CONFIDENTIAL - SECURITY INFORMATION~~

12-15-1952

156

Can you see it?

50-5-9

Johns Hopkins University

Wm. W. B. B. B.

MAYOR W. B. GAZDAR

1
W426

67 8586

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8586

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT

WALKER

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1967 7:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

631 W. Franklin St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12/2/09

9. AGE (In years lost birthday)

51

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Charlotte N Carolina

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Ernest Walker

14. MOTHER'S MAIDEN NAME

Ola

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Miss Dorothy Hall, Charlotte N C

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/10/67

23C. NAME of CEMETERY or CREMATORY

Charlotte

23D. LOCATION (City, town, or county)

North Carolina

24A. DATE REC'D BY HEALTH DEPT.

SEP 8 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Adolphus H alstead 1206 W North Ave

ADDRESS

1/2

WALTER

WALTER POHLE

DEPT. OF JUSTICE

1/2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

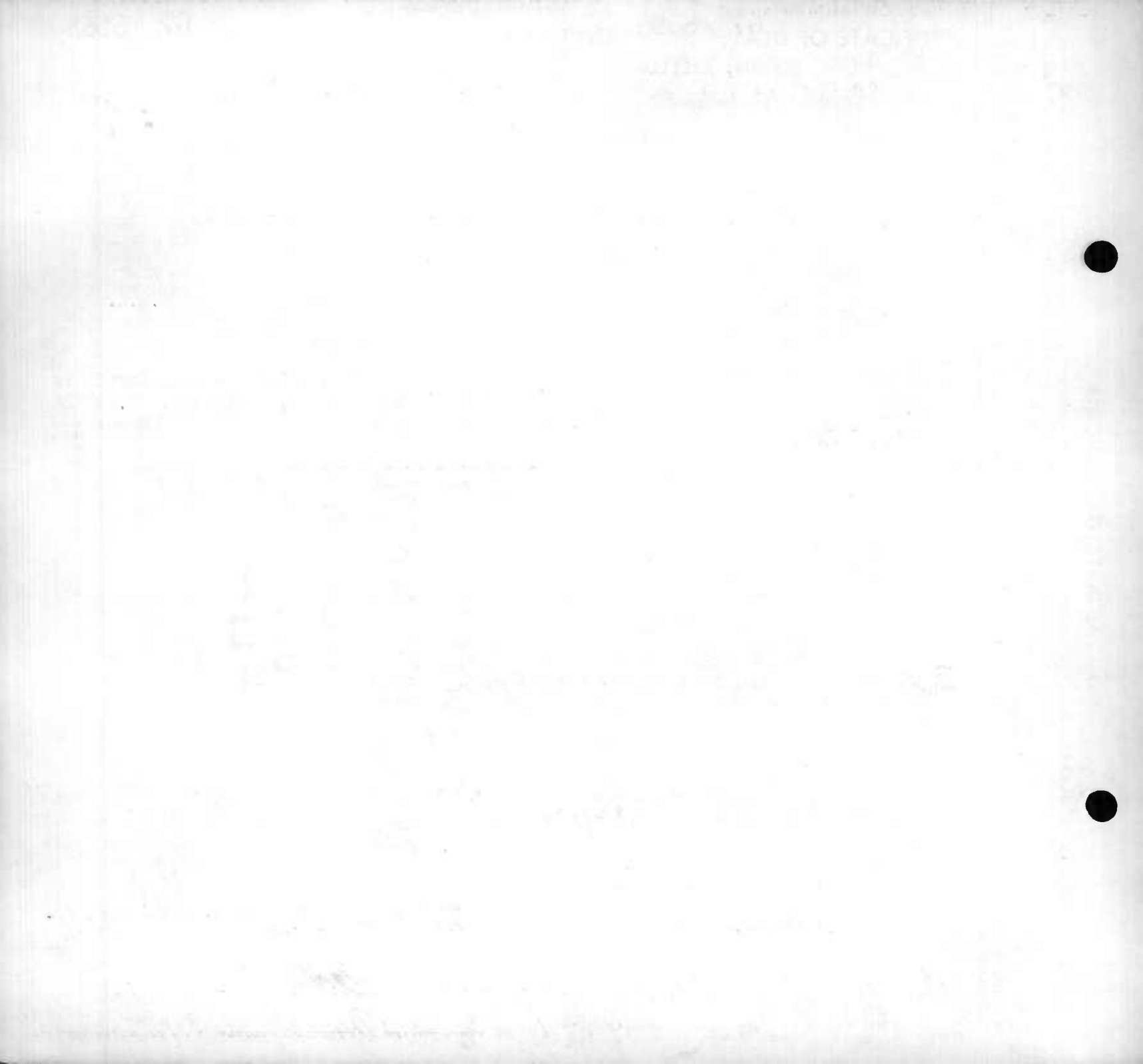
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8587	
BIRTH NO. 67 8587		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Roland Robinson	
2. DATE AND HOUR OF DEATH 8-30-67 9:40 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX Male			
A. STATE Maryland		6. RACE Negro			
B. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore,		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) ?			
C. STREET ADDRESS (If rural, give location) 1544 W. Lanvale Street		8. DATE OF BIRTH ?			
9. AGE (In years last birthday) 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Herrington, same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Septicemia leading to peripheral circulatory failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 30, 19 67 to August 30, 19 67, that (I) (we) last saw the deceased alive on August 30, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Nefancholy				23B. DATE SIGNED 8-31-67	
23C. PHYSICIAN'S NAME (Type) M.C. PANCHOLO				23D. ADDRESS M.D. 1514 Division Street Balto., Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/67		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) A A County Md		25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967			
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave			

Top Secret - Confidential
100-444444-100

W. C. RANNEY
100-444444-100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-250 BIRTH NO.		67 8588		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8588	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) COWSON, Azillie			
2. DATE AND HOUR OF DEATH 9/4/67 9:14				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 31 N. CAREY STREET - 21223			
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED		8. DATE OF BIRTH 7/4/35	
9. AGE (In years last birthday) 32		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME GENE MACK				14. MOTHER'S MAIDEN NAME MAGGIE MALLETTE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) 171X I CAUSE OF DEATH (A) Cervical cancer - stage IV - post radiation therapy (B) 3 yrs (C) INTERVAL BETWEEN ONSET AND DEATH							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 8/15/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED post op to cervical cancer - metastatic disease		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., on or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/27 19 67 to 9/4 19 67 , that (I) (we) last saw the deceased alive on 9/4/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard Lippman				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/4/67	
23C. PHYSICIAN'S NAME (Type) LEONARD LIPPMAN				M.D. 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. BAL. CITY HOSPITALS. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/1967		24C. NAME OF CEMETERY OR CREMATORY W. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Cedar Hill Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schradel St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 8589					CERTIFICATE OF DEATH		Registered No. 67 8589			
1. NAME OF DECEASED (Type or Print) <i>Joseph A. Edell (EDEI)</i>					2. DATE AND HOUR OF DEATH <i>Sept. 7, 1967</i> <i>11:50 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 3501 Hamilton Ave.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-44</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3501 Hamilton Ave.</i>					
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>Oct. 28, 1893</i>	9. AGE (In years last birthday) <i>73</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Printer</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Augustus Edell</i>	14. MOTHER'S MAIDEN NAME <i>Anna Helfrich</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW I</i>			16. SOCIAL SECURITY NO. <i>213051057</i>		17. INFORMANT <i>Mrs. Sylvia Venanzi</i>			ADDRESS <i>(Same)</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Arteriosclerosis 1 week</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Coronary Heart Disease 1 day</i>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>No</i>										
19A. DATE OF OPERATION <i>No</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i>				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>No</i>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <i>No</i>				
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 6 1967</i> to <i>Sept 7 1967</i> that (I) (we) last saw the deceased alive on <i>Sept 6 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Fred. Ruck</i>							M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Sept 7 67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Physician</i>					23D. ADDRESS M.D. <i>800 N. Patton Ave</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>9/11/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 8 1967</i>			25B. NAME OF REGISTRAR <i>Paul E. Jankowski</i>			25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>				

(143)

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1901
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 40067 8590		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8590	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FLORENCE V. BOWMAN (Deyle)		2. DATE AND HOUR OF DEATH 9/6/67 7:35 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21224 53-00 D. STREET ADDRESS (If rural, give location) 524 Southern Ave			
5. SEX FEMALE	6. RACE WHITE	7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)) Married	8. DATE OF BIRTH 10/13/92	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Housewife)		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME ISAAC HARPER			14. MOTHER'S MAIDEN NAME ANNA BOWERS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-12-7016		17. INFORMANT MEDICAL CHART ADDRESS	
18. 450.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/23 19 67 to 9/6 19 67 , that (I) (we) last saw the deceased alive on 9/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. S. Magno M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) RAYMUNDO S. MAGNO		23D. ADDRESS Franklin Square Hospital M.O.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/67		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS	

1941

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(other work)

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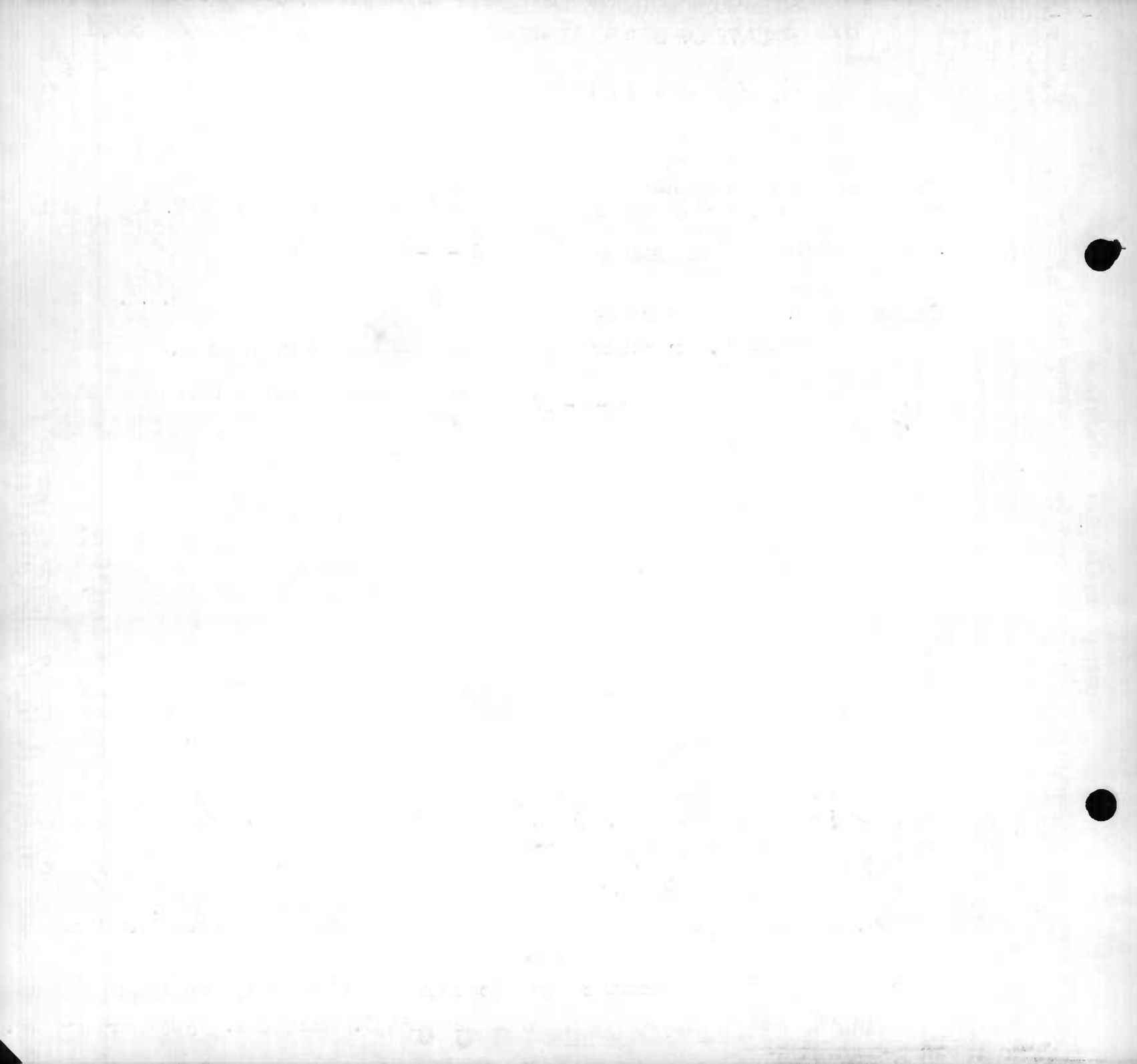
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 63 67 8591		CERTIFICATE OF DEATH		Registered No. 67 8591	
M.E. CASE NO.		1. NAME OF DECEASED KREUTZER, HENRY F.		2. DATE AND HOUR OF DEATH 1967 SEPTEMBER 7 10:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-38		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		D. STREET ADDRESS (If rural, give location) 5662 WOODMONT AVENUE		APT. D 21212	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 12-28-98	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claims Supvr.		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE H. Knuetzer		14. MOTHER'S MAIDEN NAME WEIN REICH m, Anna M.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-8578		17. INFORMANT BCN: RECORDS ADDRESS 4940 EASTERN AVENUE 21224	
18. 593 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Uremia Renal failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 28 19 67 to Sept. 7 19 67 , that (I) (we) last saw the deceased alive on Sept. 7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond La Sure		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 7, 1967	
23C. PHYSICIAN'S NAME (Type) DR. RAYMOND LA SURE		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8592				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8592	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				EDMUND Edward J. Petchik		Sept. 6, 1967 1:00 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION				Md.		12-06	
2647 North Charles Street				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
D. STREET ADDRESS (If rural, give location)				2647 North Charles Street			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
male		white		single		11/12/1909	
9. AGE (In years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
57		Vets. Administration - Finance				Penna.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Karl Petchik				Helen Mika			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
yes		WW II		195-09-4015		Miss Amelia Petchik Warramie Pa. 36 Main St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				Diabetes Mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				8 YRS.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/3 1960 to 9/6 1967, that (I) (we) last saw the deceased alive on 6/21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Barnett Berman, M.D.						9/7/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Barnett Berman				611 Park Avenue, Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/8/67		Balto. National Cem.		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 8 1967		Robert E. Taylor		Leonard J. Ruck, Inc		Baltimore, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8593	
BIRTH NO. 67 8593		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Anna Jones		2. DATE AND HOUR OF DEATH 9/7/67 11:40 A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		A. STATE Md. B. COUNTY 27-02			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3023 Overland Avenue			
5. SEX F	6. RACE W	7. MARRIAGE STATUS WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 11/14/84	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John Blume		14. MOTHER'S MAIDEN NAME Johanne Krause			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-5099		17. INFORMANT Mrs. Anna J. Stover	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
18. 5-27-11					
18. Heart failure / pleurisy					
18. Cor pulmonale					
18. emphysema					
18. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 12/67 2:00 p.m. to Sept 7/67 11:40 A.M. that (I) (we) last saw the deceased alive on Sept 7/67 11:00 A.M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DR RAHIMI				23B. DATE/SIGNED 9/7/67	
23C. PHYSICIAN'S NAME (Type) Abbas RAHIMI				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leona rd J. Ruck, Inc. Balto. Md. 21214	

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• **1992** – 1993

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

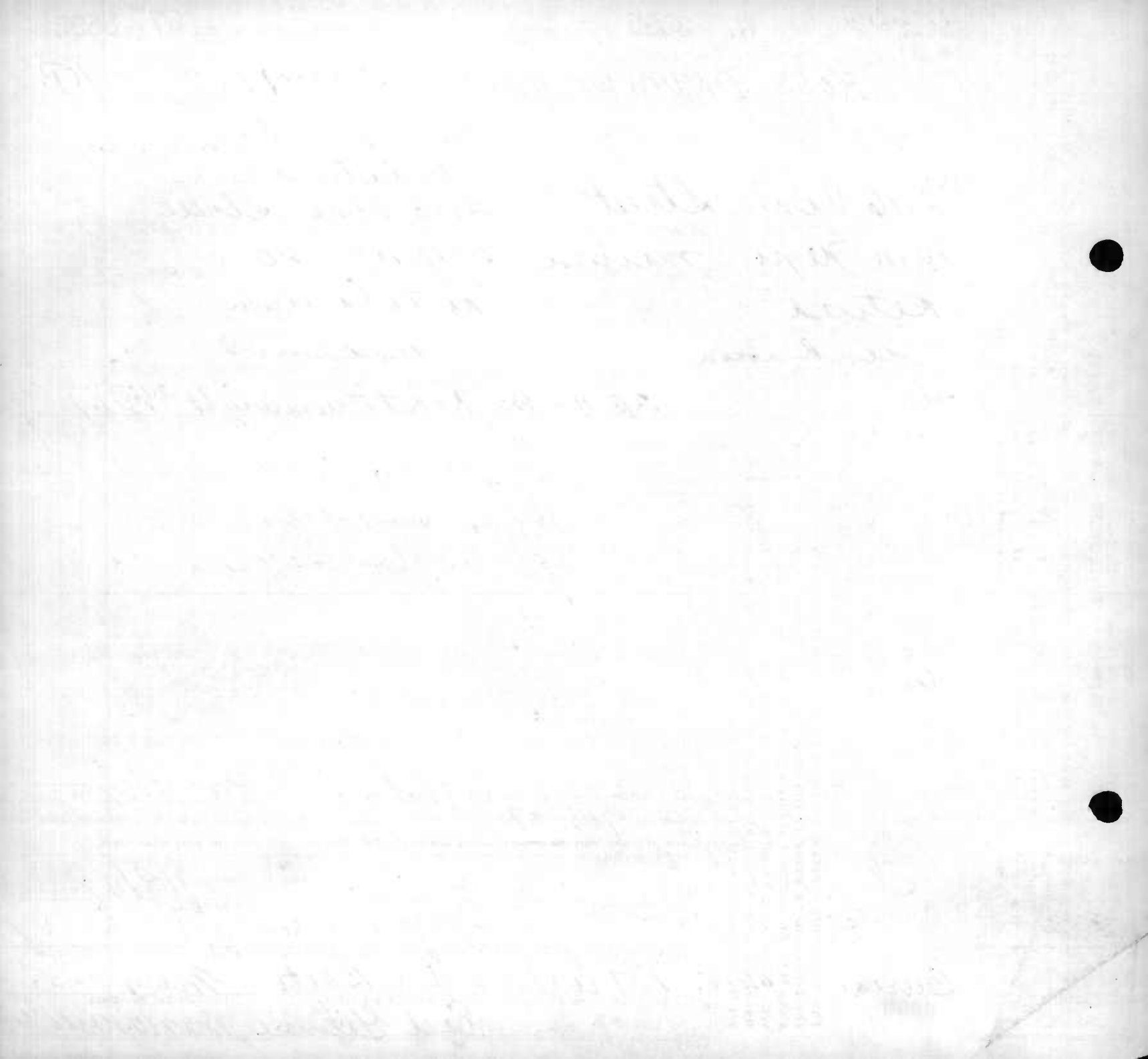
H-560 BIRTH NO.		67 8594		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8594	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) FRANK HENRY JR.				2. DATE AND HOUR OF DEATH 9/5/67 3:05 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #24 D. STREET ADDRESS (If rural, give location) 3018 ELLIOTT ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-16-10	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED- Locomotive Eng. Beth. Steel			10B. KIND OF BUSINESS OR INDUSTRY Ship Yard		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME FRANK HENRY SR.			14. MOTHER'S MAIDEN NAME MARY E. SAUNDERS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-4327		17. INFORMANT Mrs. Marie Henry, 3018 Elliott St. Balto. Md.			ADDRESS 21224
18. 5-27-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilat. confluent bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Emphysema + bronchiectasis				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-28 19 67 to 9-5 19 67 , that (I) (we) last saw the deceased alive on 3:05 PM 9-5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Byung Kap Kang M.D.						23B. DATE SIGNED 9-5-67	
23C. PHYSICIAN'S NAME (Type) BYUNG KAP KANG M.D.				23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Pk. Cem.		24D. LOCATION (City, town, or county) (State) Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR John [Signature] ADDRESS 7422 [Address]			

Hotel der Stadt Hamburg
Hamburg

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-656 BIRTH NO.		67 8595 BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8595	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROSS DRUM WRIGHT		2. DATE AND HOUR OF DEATH Sept 8, 1967 3:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 2116 Vine Street		A. STATE Maryland B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give town ship) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2116 Vine Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3/4/1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-10-5682		17. INFORMANT Robert Drumwright	
18. 442 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory failure		CAUSE OF DEATH (A) DUE TO Hypertension - (B) DUE TO Vascular renal disease		ADDRESS 2450 W. Belvoir INTERVAL BETWEEN ONSET AND DEATH 7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/16/67 to 9/8/67 19____, that (I) (we) last saw the deceased alive on 9/8/67 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Sborofsky		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) S. Sborofsky		23D. ADDRESS 601 N. Marine St. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem	
24D. LOCATION Balto. Maryland.		25A. DATE RECD BY HEALTH DEPT. SEP 11 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Earl Gilmore			
25D. ADDRESS 1827 W. North Ave					



1
5-500

67 8596 BALTIMORE CITY HEALTH DEPARTMENT

67 8596

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

(Carl)

CLIFFORD SWIM

2. DATE AND HOUR PRONOUNCED DEAD

September 7, 1967 11:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

205 N. Rose Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Sept. 29, 1957

9. AGE (In years
last birthday)

9

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Schoolboy

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Wash. D. C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Clifford C. Swim

14. MOTHER'S MAIDEN NAME

Harriet Gaumer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

--

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Harriet Swim, 205 N. Rose St. 24

18.

E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Multiple traumatic injuries

(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

(Partial)

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Orleans and Rose Streets

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9-7-67 10:10 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE AT
WORK

(Partial)

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Charles S. Springate
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept. 11th, 67 Meadowridge Mem. Pk.

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Elkridge Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

Robert E. Fink

24C. FUNERAL DIRECTOR

Philip's Funeral Home

ADDRESS

2024 Orleans St.

N 869.2

WALLACE ROMER

WALLACE ROMER

Handwritten signature

5-363

67 8597

BALTIMORE CITY HEALTH DEPARTMENT

67 8597

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VIVIAN

Sturdivant
STRUTEVAT

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1967 10:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3409 Walbrook (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3905 Bonner Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1-5-1944

9. AGE (in years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jesse H. Gaddis

14. MOTHER'S MAIDEN NAME

Rachel Pryor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Rachel Eaton 2047 Bentall St

18.

323X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Overdose of Narcotics
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

9/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-7-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 11 1967

R. E. E. Johnson

Aslington Phillips

1727 N. Mount St.

W. L. L. L.

WALLLEY POLICE

W. L. L. L.

W. L. L. L.

W. L. L. L.

W. L. L. L.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8598	
BIRTH NO. 67 8598		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>George C. McKnight Sr.</u>		2. DATE AND HOUR OF DEATH <u>9/6/67</u> <u>7:45A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>25-32</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>21225</u>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>3544 Round Road</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5/16/70</u>	9. AGE (In years lost birthday) <u>97</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>James McKnight</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Morris</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-54-9741</u>		17. INFORMANT ADDRESS <u>George McKnight Jr. 712 Richmond Ave.</u>	
18. <u>592X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>Uremia</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 MW - DOCUMENTED</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Chronic Renal Disease</u> DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>41</u> (this hospital) attended the deceased from <u>8/9</u> 19 <u>67</u> to <u>9/6</u> 19 <u>67</u> , that <u>41</u> (we) last saw the deceased alive on <u>9/6</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas H. Emory</u> M.D.				23B. DATE SIGNED <u>9/6/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>THOMAS H. EMORY</u>		23D. ADDRESS <u>SB6N.</u> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>9-8-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bentley's Hill</u>	
24D. LOCATION (City, town, or county) (State) <u>Georgia</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1967</u>		25B. NAME OF REGISTRAR <u>Admiral S. Phillips</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1727 N. Monroe St.</u>	



67 8599

BALTIMORE CITY HEALTH DEPARTMENT

67 8599

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN DATES

2. DATE AND HOUR PRONOUNCED DEAD

September 6, 1967 12:10 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1224 Rossiter Ave. Apt. 3B

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

d

8. DATE OF BIRTH

3-30-1928

9. AGE (In years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Interview

10B. KIND OF BUSINESS OR INDUSTRY

Dept. Welfare

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Marvin H. Dates

14. MOTHER'S MAIDEN NAME

Emma K. Crampton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-28-6420

17. INFORMANT

Emma K. Dates

ADDRESS

Same

18.

330 X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Subarachnoid hemorrhage
rupture of berry aneurysm

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 6, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-9-67

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Ch. Baltimore

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Orlington, Phillips 1727 Moore St.

ADDRESS

EXHIBIT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. *See above*

BIRTH NO. 67 8600		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8600	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JENNIE M. WEAVER		8 Sept 67		2:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 227 NORTH LUZERNE AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 9-06-73	9. AGE (In years last birthday) 94	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME ANTON PERINA		14. MOTHER'S MAIDEN NAME FRANCES SCHONFLOCK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-54-4688T		17. INFORMANT JOAN E. MCHE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) cardiac arrest		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic cardiovascular disease		20. CAUSE OF DEATH fracture @ hip	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. DATE OF OPERATION 15 July 67		23. DATE OF OPERATION 14 July 67	
24. DATE OF OPERATION 15 July 67		25. CONDITION FOR WHICH OPERATION WAS PERFORMED fracture @ hip		26. AUTOPSY? (Yes or No) NO	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
33. I certify that (I) (this hospital) attended the deceased from 14 July 67 to 8 Sept 1967 , that (I) (we) last saw the deceased alive on 8 Sept 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
34. SIGNATURE Richard E. Preinger		35. DATE SIGNED 8 Sept 67		36. PHYSICIAN'S NAME (Type) RICHARD E. PREINGER	
37. ADDRESS JOHNS HOPKINS HOSPITAL		38. BURIAL CREMATION, REMOVAL (Specify) BURIAL		39. DATE 10/12/67	
40. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL		41. LOCATION (City, town, or county) (State) EDMONDSON AVE		42. DATE RECD BY HEALTH DEPT. SEP 11 1967	
43. NAME OF REGISTRAR Robert E. Taylor		44. FUNERAL DIRECTOR JOHN M. WEBERSON'S INC		45. ADDRESS 401 S. CHESTER ST	

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10/2/61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 8601		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8601	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		MARIA RASPA		2. DATE AND HOUR OF DEATH 9/6/67 11:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE, 1-02	
		D. STREET ADDRESS (If rural, give location)		211 SO. ELLWOOD ST.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1-10-1892	9. AGE (In years lost/birthday) 75	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Travaglini		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? No	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 314-56-6809		17. INFORMANT Mr. Frank Raspa	
		ADDRESS		Same	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		None			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/1 1967 to 9/6 1967, that (I) (we) last saw the deceased alive on 9/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dudley D. Goulden III M.D.				23B. DATE SIGNED 9/6/67	
23C. PHYSICIAN'S NAME (Type) DR. DUDLEY GOULDEN 3RD. M.D.				23D. ADDRESS	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/67		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cem	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Joseph M. Zannone		25C. FUNERAL DIRECTOR 263 S Conkling St	

None

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 64-0058967		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8602	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Wanda L. Maxson			2. DATE AND HOUR OF DEATH 9/8/67 120 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 John Hopkins Hospital			A. STATE Maryland B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Relay		
			D. STREET ADDRESS (If rural, give location) 1722 S. Rolling Road #28		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Child Single	8. DATE OF BIRTH 1-3-1964	9. AGE (In years last birthday) 3	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Donald L. Maxson			14. MOTHER'S MAIDEN NAME Ina R. Major		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS 21227 Mr. Donald L. Maxson, 1722 S. Rolling Rd.		
18. 752X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hydrocephalus			INTERVAL BETWEEN ONSET AND DEATH 3 years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Coma 2° Hydrocephalus		
19A. DATE OF OPERATION 9/11/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Removal of Foreign matter		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/14 1967 to 9/8/67 that (I) (we) last saw the deceased alive on 9/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl E. Bucleubey				23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) Dr. Carl E. Bucleubey				23D. ADDRESS John Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-1967		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
				24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue 21229	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 8603		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8603	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>ALMA WOOD</i>	
2. DATE AND HOUR OF DEATH <i>SEPTEMBER 8, 1967 7:53 A.M.</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 27-05</i>			
D. STREET ADDRESS (If rural, give location) <i>4006 FLEETWOOD AVE.</i>		5. SEX <i>F</i>			
6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>9/10/97</i>	
9. AGE (In years last birthday) <i>69</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>(UNKNOWN) LANGALHAN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-05-0750</i>		17. INFORMANT <i>Mr Maurice Wood 4006 Fleetwood Avenue #6</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>ASCVD - Coronary Occlusion (2 coronary art.) Pulmonary edema - effusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Manual Jerning w.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/8</i> <i>1967</i> to <i>9/8</i> <i>1967</i> , that (I) (we) last saw the deceased alive on <i>9/8</i> <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>W. H. Cehlert</i>				23B. DATE SIGNED <i>9/8/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>M.D.</i>		23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-11-1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Lassahn Funeral Home 7401 Belair Road</i>			

March Memorial Lecture
F. W. Mendenhall
Housewife
(Mendenhall) Mendenhall

Not recorded
April 22
Mendenhall
Unknown

Agenda
General Session
(Lecture at)
February 28
Office

Presidential Address

Yes

W. H. C. Mendenhall

x

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-152		67 8604		BALTIMORE CITY HEALTH DEPARTMENT		SPENCER, LEMUEL		Registered No. 67 8604	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				LEMUEL F. SPENCER		9-4-67		1:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				BALTIMORE					
				D. STREET ADDRESS (If rural, give location)					
				701 E. 21st St.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.			
MALE	NEGROID	MARRIED	8-1-80	87					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired		U. S. Gov't		Norfolk, Virginia		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
LEMUEL F. Spencer				MOLLY Kelling					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
				Decedent					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
466X1		Cerebral or myocardial infarct				1 min			
ANTECEDENT CAUSES		(B) Irregular vein thrombosis				1 mo ago			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Pneumonia				3 wks ago			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
8/26/67		Biopsy of mass		No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 9/1/67 to 9/4/67, that (I) (we) last saw the deceased alive on 9/4/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
Thomas C. Butler						9/4/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
THOMAS C. BUTLER				601 N. BROADWAY					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		9/9/67		Lincoln Memorial Cem.		Suitland, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
SEP 11 1967		Robert G. McGuire		Robert G. McGuire		1820 9th St., N. W. Wash., D. C.			

Central or important agent
Friedrich von Thunhausen
Friedrich von Thunhausen

Biography of von Thunhausen

8/10/07

12/1/07

12/1/07

12/1/07

12/1/07

Thomas C. Butler
THOMAS C. BUTLER

1
R-250

67 8605

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 8605

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BARBARA RUSEN

2. DATE AND HOUR PRONOUNCED DEAD

September 6, 1967 3:14 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Fullerton

D. STREET ADDRESS (If rural, give location)

700 Dale Avenue 21206

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

7-24-1955

9. AGE (in years
last birthday)

12

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

Student

11. BIRTHPLACE (State or foreign country)

Baltimore City Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward B. Rusen

14. MOTHER'S MAIDEN NAME

Beathrice L. Amersbach

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Mr Edward B. Rusen 700 Dale Avenue #6

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Rear 500 Dale Avenue behind
Elmwood Elementary School - Baltimore21D. TIME OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9-6-67 2:40 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE AT
WORK

21F. HOW DID INJURY OCCUR?

Fell to ground from high pole.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 7, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-9-1967

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

23D. LOCATION

Baltimore Co.

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

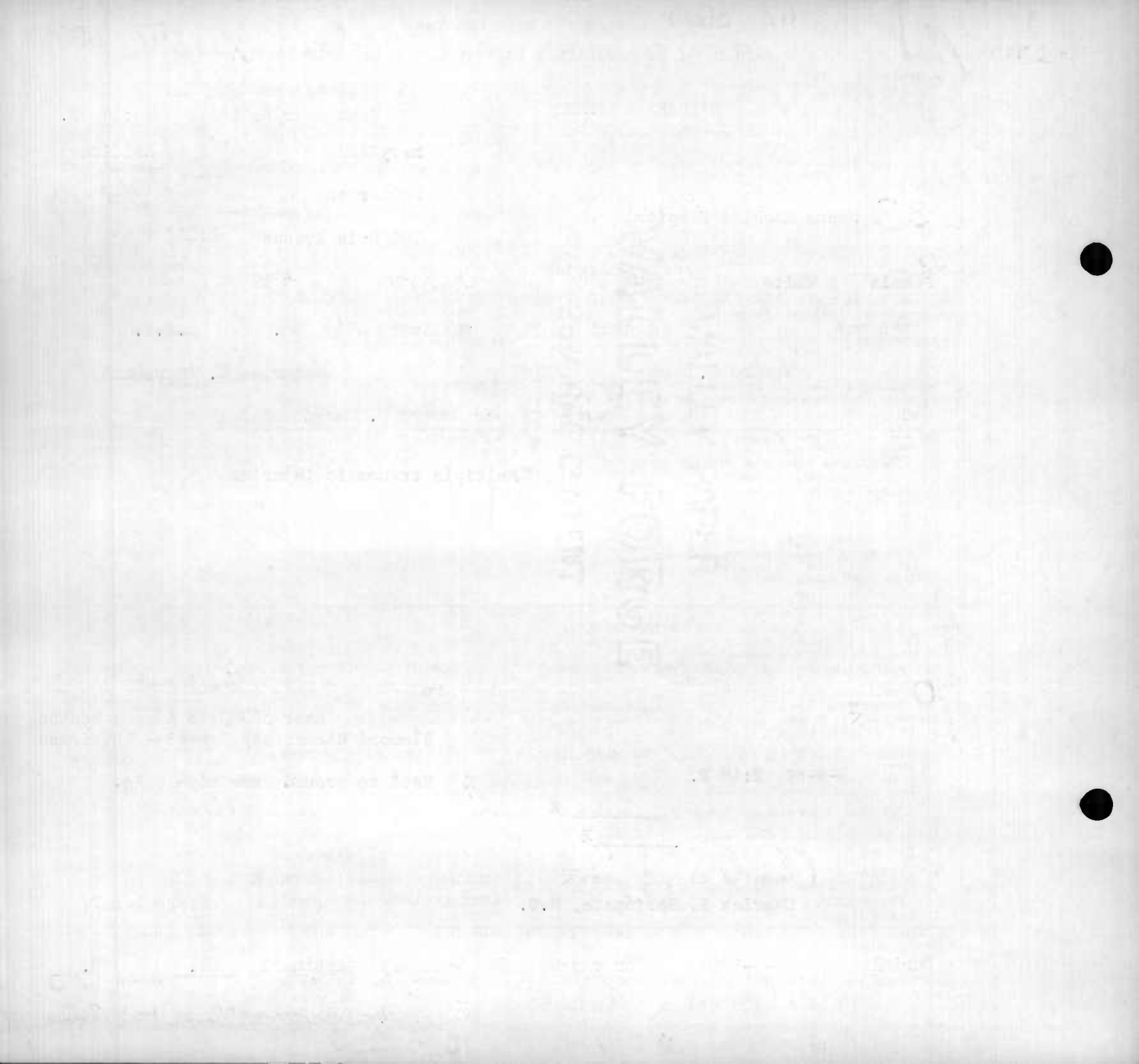
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Lassahn Funeral Home 740 Belair Rd

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8606

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Frank L. Neville Sr.

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1967 5:58 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FRANK NEVILLE Sr.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Dundalk

D. STREET ADDRESS (If rural, give location)

7424 Poplar Ave.

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

6/11/04

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Coal Miner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Neville

14. MOTHER'S MAIDEN NAME

Catherine Masemore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

187/01/0438

17. INFORMANT (Son)

Mr. Frank L. Neville Jr. 7424 Poplar Ave.

Dundalk, Md. 21222

E 820-91

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Subdural hematoma, old, remote, right
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Aortic Valvular Stenosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

app. 4 months ago

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

In automobile accident

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/12/67

23C. NAME of CEMETERY or CREMATORY

Odd Fellows Cemetery

23D. LOCATION

(City, town, or county)

(State)

Broad Top City, Huntingdon Co.
Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

John J. Duda, 7922 Wise Ave. Dundalk, Md.

WILLIAM H. HARRIS

William H. Harris

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8607		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8607	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BESSIE P. MORGAN			2. DATE AND HOUR OF DEATH SEPT. 9, 1967 7:30 a. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Mount Convalescent Home 3706 Nortonia R.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Sparrows Point D. STREET ADDRESS (If rural, give location) 809 "E" Street 21219		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 9/17/85	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Conrad Zink			14. MOTHER'S MAIDEN NAME Amanda ??		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Son) Laurel, Delaware Mr. Dwinton O. Morgan, 108 Evergreen Dr.	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) cerebral thrombosis DUE TO (B) cerebral arteriosclerosis DUE TO (C) unknown INTERVAL BETWEEN ONSET AND DEATH 2 years unknown			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 9, 1965 to Sept. 9, 1967, that (I) (we) last saw the deceased alive on Sept. 2, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz M.D.				23B. DATE SIGNED Sept. 9, 1967	
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ				23D. ADDRESS 7501 LIBERTY ROAD, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME of CEMETERY or CREMATORY Jessops Methodist Church Cem.	
24D. LOCATION Cockeysville, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda			
25D. ADDRESS 7922 Wise Ave. Dundalk, Md.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8608	
BIRTH NO. 67 8608		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Idelle M. Welsh (Idelle M. Faulkner)		2. DATE AND HOUR OF DEATH September 9, 1967 12:50 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Inc. 1514 Division Street Baltimore, Maryland 21217		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 837 West Harlem Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/28/1899	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk/Brilliant Cleaners		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ARRINGTON			14. MOTHER'S MAIDEN NAME IRENE MORGAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-03-2403		17. INFORMANT William Welsh (husband)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Heart Block		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 9/9/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 8, 1967 to September 9, 1967 , that (I) (we) last saw the deceased alive on September 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gregorio S. Paez				23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) Gregorio S. Paez		23D. ADDRESS 1514 Division Street Balto., Md. 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME OF CEMETERY or CREMATORY BALTO MD 21225	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Faulkner		25C. FUNERAL DIRECTOR Marshall P. Paez	
				ADDRESS 6387 Gilmor St	

CONFIDENTIAL

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CONFIDENTIAL

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8609

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPHINE MUCHLA

2. DATE AND HOUR PRONOUNCED DEAD

September 3, 1967 9:30 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35

Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2616 Foster Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

B. DATE OF BIRTH

3-19-1896

9. AGE (In years
lost birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

MICHAEL JAWORSKI

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. MARIE SLOWAKIEWICZ 4508 SPRINGWOOD AVE

18.

443 X₁

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Hypertensive and arteriosclerotic
cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9-6-67

23C. NAME of CEMETERY or CREMATORY

SACRED HEART OF JESUS

23D. LOCATION

(City, town, or county)

BALTIMORE MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

Robert E. Faldut

24C. FUNERAL DIRECTOR

RAYMOND L. KACZOROWSKI

ADDRESS

2525 FLEET ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8610		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8610	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MINNA LEE COLLINS		2. DATE AND HOUR OF DEATH 9/7/67 16:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE Co.			
FULL NAME OF HOSPITAL OR INSTITUTION 90 HOOD CONV. HOME		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 21229 53-00			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 210 WESTSHIRE DR.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/27/89	9. AGE (in years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH ANDERSON		14. MOTHER'S MAIDEN NAME AMERICA SUMMERLIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JAMES F. COLLINS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 350X I Terminal Hypertension		CAUSE OF DEATH (A) DUE TO Pneumonia (B) DUE TO Paralysis Agitans (C) Terminal Phase		INTERVAL BETWEEN ONSET AND DEATH 5 days Many years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/14/67 1962 to 9/7/67 1967, that (I) (we) last saw the deceased alive on 9/7/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. My associate					
23A. SIGNATURE Elmer W. Johnson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON		23D. ADDRESS 3432 Frederick Avenue BALTIMORE MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/11/67		24C. NAME of CEMETERY or CREMATORY LORRAINE	
24D. LOCATION (City, town, or county) (State) BALTO. Co. MD.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR R. E. Johnson	
25C. FUNERAL DIRECTOR E. S. MAGNABB		25D. ADDRESS 301 FREDERICK RD 21228			

WILLIAM LEE GORDON

PO BOX 100
CHATELAIN
212 WESTSHORE DR.

STATE OF NY

HERD GRASS FARM
IN
SINKHOLE

NO. 1000000

JOSEPH ANDERSON

NO

JAMES F. FORD

APRIL 10 1900

THE STATE OF NEW YORK
IN SENATE
JANUARY 10 1900

PRINTED BY THE STATE

STATE OF NEW YORK
JANUARY 10 1900

1
G-321

67 8611 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8611

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
HARRY GOTTESFIELD		September 6, 1967 9:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
422.1 99 Sinai Hospital (DOA)		Pennsylvania	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Philadelphia V-35	
		D. STREET ADDRESS (If rural, give location)	
		482 W. Airdri Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Male	White	WIDOWED	Nov 29, 1894
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
EMOL.		STATE OF PA	73
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
PHILA, PA		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
ISRAEL		LEAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		186-03-3699	
17. INFORMANT		ADDRESS	
MRS JEANNE ZALESKY		4016 EMMART AVE	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED		September 7, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	9/8/67	KING DAVID	PHILA, PA
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	
SEP 11 1967	Robert E. Farley, M.D.	Sylvan S. Lewis & Son, INC	

19670000631

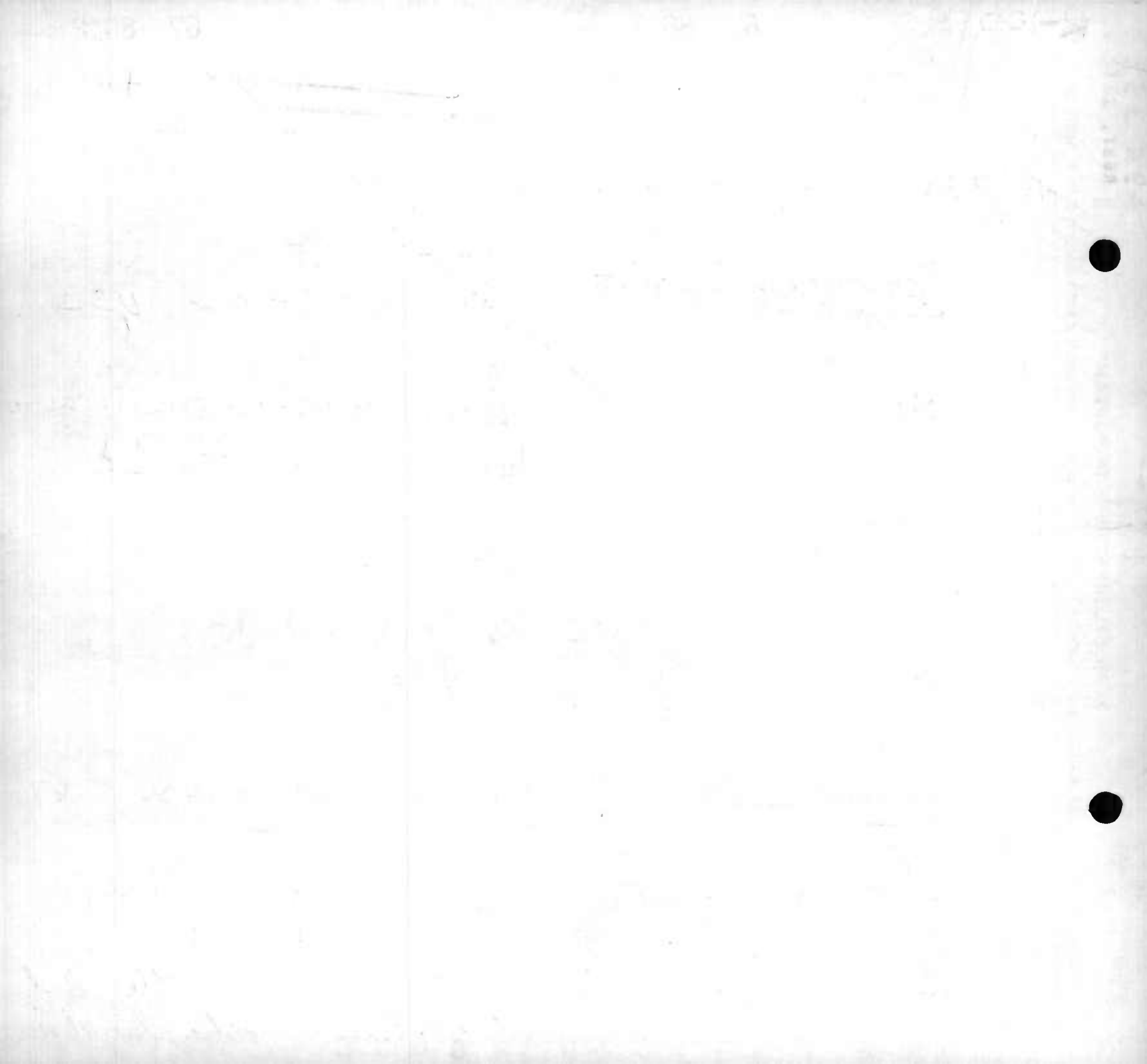
ALLEN HODGKIN

94 3512
ROBY, KATE W.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

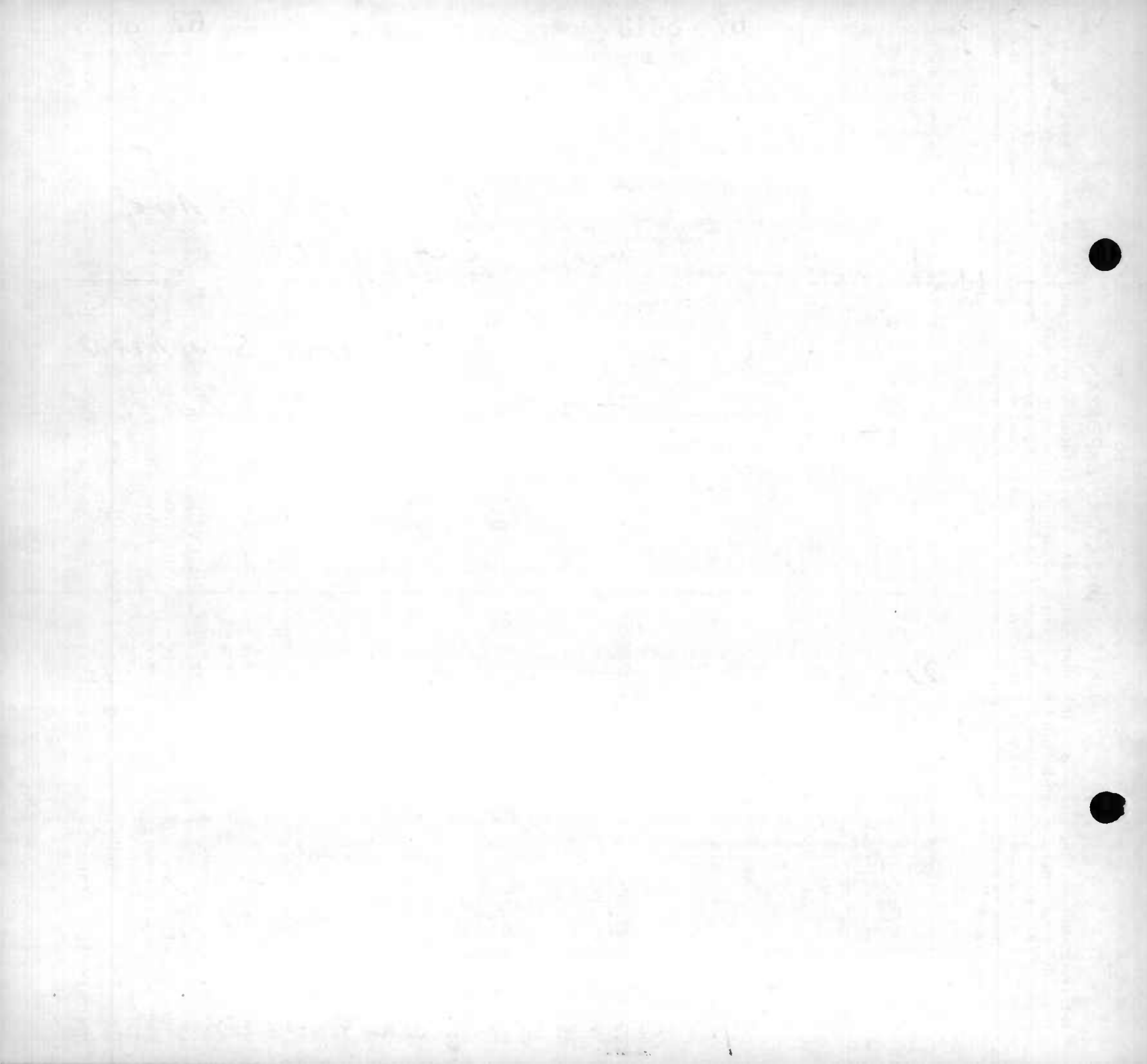
BIRTH NO. 67 8612		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8612	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KATE W. ROBY		2. DATE AND HOUR OF DEATH AUG 30 1967 4:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY PRINCE GEORGE		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BELTSVILLE	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 111807 GUNPOWDER ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-28-95	9. AGE (In years) 71	10. USUAL OCCUPATION (Give kind of work done during past week or two) HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during past week or two) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) DEGRAFF, OHIO	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM WALKER		14. MOTHER'S MAIDEN NAME ALICE KRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOHNS HOPKINS HOSPITAL DAUGHTER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-22-11 myocardial infarction 1 day		CAUSE OF DEATH (A) DUE TO Hypertension or infection AS CVD (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GI bleeding, Rheumatic HTN.		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. HOW DID INJURY OCCUR?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUG 24 1967 to AUG 30 1967, that (I) (we) last saw the deceased alive on AUG 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Harry K. Genant		23B. DATE SIGNED 8/30/67	
23C. PHYSICIAN'S NAME (Type) HARRY K. GENANT		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 9/2/67		24C. NAME OF CEMETERY or CREMATORY Union Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR R. E. F. F.		25C. FUNERAL DIRECTOR R. E. F. F.	
25D. ADDRESS R. E. F. F.		25E. ADDRESS R. E. F. F.		25F. ADDRESS R. E. F. F.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

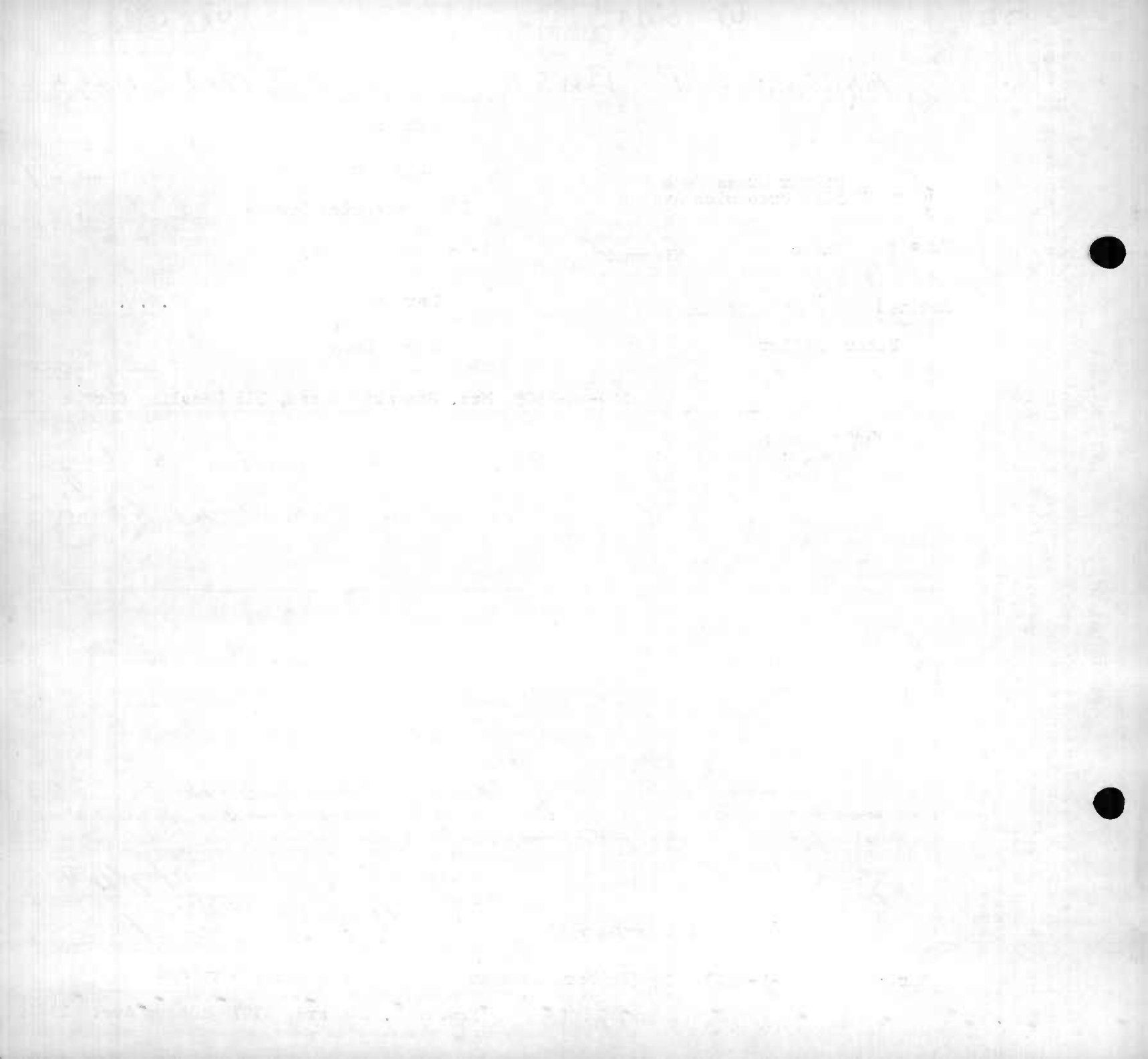
BIRTH NO. 67 8613		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8613	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mr Dietz, Charles		2. DATE AND HOUR OF DEATH 9-8-67 17:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. General Hosp		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 4306 Glenmore Ave	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8/24/00	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY Painter		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Henry Dietz		14. MOTHER'S MAIDEN NAME Wilhelmina Spielman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 219-05-4929A		17. INFORMANT ADDRESS Niece (Mrs Dittmar) SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443 XI		CAUSE OF DEATH (A) DUE TO Cerebrovascular accident		INTERVAL BETWEEN ONSET AND DEATH Recent	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Hypertensive C-V. disease years			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 9/8/67 to 9/8/67, that (I) (we) last saw the deceased alive on 9/8/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Frank J. Zorick M.D.		23B. DATE SIGNED 9-8-67			
23C. PHYSICIAN'S NAME (Type) FRANK J. ZORICK M.D.		23D. ADDRESS Maryland Gen'l Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-1967		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lassak & Home 7401 Belair Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8614		67 8614			
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARGARET P. BUSH		Sept 7, 1967 1:50 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Silver Cross Home 5124 Greenwich Avenue		A. STATE Maryland			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		5124 Greenwich Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-1-1872	9. AGE (In years last birthday) 95	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Peter Miller		14. MOTHER'S MAIDEN NAME Nancy Cavey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-44-8909		17. INFORMANT Mrs. Stewart Duncan, 311 Wessling Circle	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I myocardial infarction 5 days arteriosclerotic heart disease unknown INTERVAL BETWEEN ONSET AND DEATH		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to Sept 1967, that (I) (we) last saw the deceased alive on Sept 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Leo J. Gaver		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/7/67	
23C. PHYSICIAN'S NAME (Type) LEO J. GAVER		23D. ADDRESS 11 mallow hill ave Baltimore, md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-9-1967	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8615		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8615	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HENRY KOUWENHOVEN		2. DATE AND HOUR OF DEATH 9/8/67 11:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Ind. B. COUNTY WORCESTER Co		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Snow Hill 73-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hosp, Marburg 2 Hall		D. STREET ADDRESS (If rural, give location) RFD 1			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug 26, 1895	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. DRIVER		10B. KIND OF BUSINESS OR INDUSTRY INVESTMENT Corp.		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ABRAHAM KOUWENHOVEN		14. MOTHER'S MAIDEN NAME MARY V. HOTT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 65-16-9432A		17. INFORMANT Mrs. CLARA F. KOUWENHOVEN, Sister	
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Ventricular fibrillation → arrest 5-10 min DUE TO (B) ? DUE TO (C) Exp of M.I. 3 yrs ago angina		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/8/67 11:25 AM to 9/8/67 12:00 AM , that (I) (we) last saw the deceased alive on 9/8/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Michaelson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) PAUL E. MICHAELSON		23D. ADDRESS M.D. JPHNS HOPKINS HOSPITAL			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Sept 13, 1967		24C. NAME OF CEMETERY or CREMATORY FLUSHING CEMETERY	
24D. LOCATION (City, town, or county) (State) FLUSHING, L.I., New York		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Feltman	
25C. FUNERAL DIRECTOR Guido's Funeral Home		25D. ADDRESS Snow Hill, Md.			

My dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,

J. H. [Signature]

Enclosed for you are the documents referred to in my letter of the 10th inst.

I am, Sir, very respectfully,
Your obedient servant,

J. H. [Signature]

I am, Sir, very respectfully,
Your obedient servant,

J. H. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8616				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8616	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MRS MAY M. EVANS				2. DATE AND HOUR OF DEATH 9-7-67 1500 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL 48				A. STATE Md B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21219 Edgemere			
				D. STREET ADDRESS (If rural, give location) 2636 MASSETH AVE.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/1/92	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ?? Reynolds			14. MOTHER'S MAIDEN NAME Not Known				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 21218-5006		17. INFORMANT (Husband) Edgemere, Md. Mr. John T. Evans, 2636 Masseth Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.11				CAUSE OF DEATH MYOCARDIAL INFARCTION ACUTE		INTERVAL BETWEEN ONSET AND DEATH RECENT	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ASCVD DUE TO		YEARS	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Cerebral Thromboses		RECENT	
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-75-67 19 67 to 9-7 19 67 , that (I) (we) last saw the deceased alive on 9-7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Frank J. Zorick M.D.						23B. DATE SIGNED 9-7-67	
23C. PHYSICIAN'S NAME (Type) FRANK J. ZORICK M.D.				23D. ADDRESS MARYLAND General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME of CEMETERY or CREMATORY Jessops Methodist Church Cem.		24D. LOCATION (City, town, or county) (State) Cockeysville, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	

SECRET

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

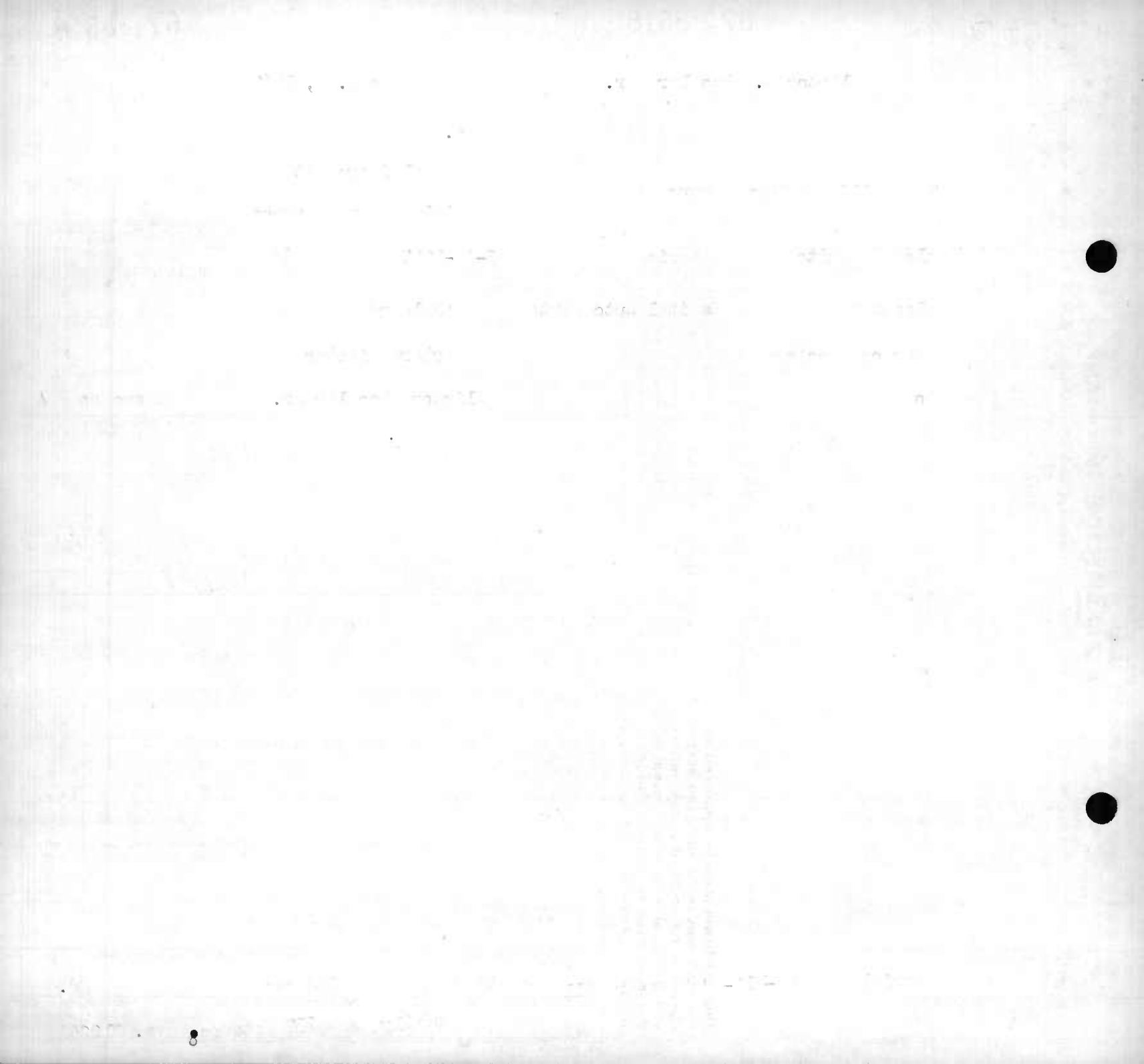
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8617	
BIRTH NO. 67 8617		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FERRELL, Elmer Roy		2. DATE AND HOUR OF DEATH September 7 1967 11:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 27 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4212 Curtis Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/13/00	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coast Guard Retired		10B. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Ferrell			14. MOTHER'S MAIDEN NAME Lula Quinn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/27/17 to 8/13/18		16. SOCIAL SECURITY NO. 215-01-2617	17. INFORMANT Records		ADDRESS V.A. Hospital, 3900 Loch Raven Blvd. Balto. Md.
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) Right Hemiparesis Secondary to Cerebral Arteriosclerosis (B) Many Years (C) Many Months		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from April 4, 1967 to September 7, 1967 , that he (we) lost saw the deceased alive on September 7, 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) not view the body after death.					
23A. SIGNATURE Zaheer Ud Din M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7/9/67	
23C. PHYSICIAN'S NAME (Type) ZAHEER-UD-DIN M.D.				23D. ADDRESS V.A. Hospital, Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-67		24C. NAME OF CEMETERY or CREMATORY Bq Hto. Natl. Cem.	
24D. LOCATION Bq Hto., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967			
25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR McGulley			
25D. ADDRESS 237 Patapsco Ave. Balto. Md. 21225					

James W. Allen
Lancaster-PA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8618		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8618	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Clinton H. Wheeler Sr.		2. DATE AND HOUR OF DEATH Sept. 8, 1967 730A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 322 Washburn Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City 25-04 D. STREET ADDRESS (If rural, give location) 322 Washburn Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-28-1907	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Capital Auto Parts		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harmon Wheeler		14. MOTHER'S MAIDEN NAME Barbara Fischer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Clinton Wheeler Jr. ADDRESS Same as # 4	
18. 420.1-1260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC MYOCARDIAL DISEASE ISCHEMIA DUE TO CORONARY SCLEROSIS - HYPERTENSION ARTEROSCLEROSIS - DIABETES MELLITUS		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 26, 1962 to Sept 8, 1967, that (I) (we) last saw the deceased alive on 9-1-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis J. Glass		23B. DATE SIGNED 9/8/67			
23C. PHYSICIAN'S NAME (Type) LOUIS J. GLASS M.D.		23D. ADDRESS 320 PATAPSCO AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-1967		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR ADDRESS McCully 237 PatapSCO Ave. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE RELEASED ON APPROVAL BY DR. SPRINGDALE OF THE MEDICAL CERTIFICATION

BIRTH NO. 67 8619				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 67 8619	
1. NAME OF DECEASED (Type or Print) CONSTANCE DAMICO				2. DATE AND HOUR OF DEATH 9/7/67 4:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL Co.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERNA PARK 52-00			
D. STREET ADDRESS (If rural, give location) ROUTE #2 BOX 543 CARROLLTON MANOR							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-6-00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 25060549A		17. INFORMANT Anthony Damico - Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E903.0				CAUSE OF DEATH Respiratory insufficiency, pulmonary embolus, Tri-malleolar fracture @ ankle		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ROUTE 2 BOX 543, CARROLLTON MANOR, SEVERNA PARK	
21D. TIME OF INJURY (APPROX.) 8-12-67 10 PM				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? SPILLED GREASE, THEN SLIPPED AND FELL 52-00	
22. I certify that (I) (this hospital) attended the deceased from 8/17 19 67 to 9/7 19 67 , that (I) (we) last saw the deceased alive on 9/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE H. Michael Meagher				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/7/67	
23C. PHYSICIAN'S NAME (Type) HENRY M. MEAGHER				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem Balt		24D. LOCATION (City, town, or county) (State) Severna Park Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert S. Barrauco		25C. FUNERAL DIRECTOR Robert S. Barrauco		ADDRESS Severna Park Md.	

SEP 11 1967

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Handwritten text, possibly a name or title, located in the upper far left section of the page.

Handwritten text, possibly a name or title, located in the middle right section of the page.

Large handwritten text block, possibly a signature or a detailed note, located in the center of the page.

Handwritten text, possibly a date or reference number, located in the lower right section of the page.

Handwritten text, possibly a date or reference number, located in the lower middle section of the page.

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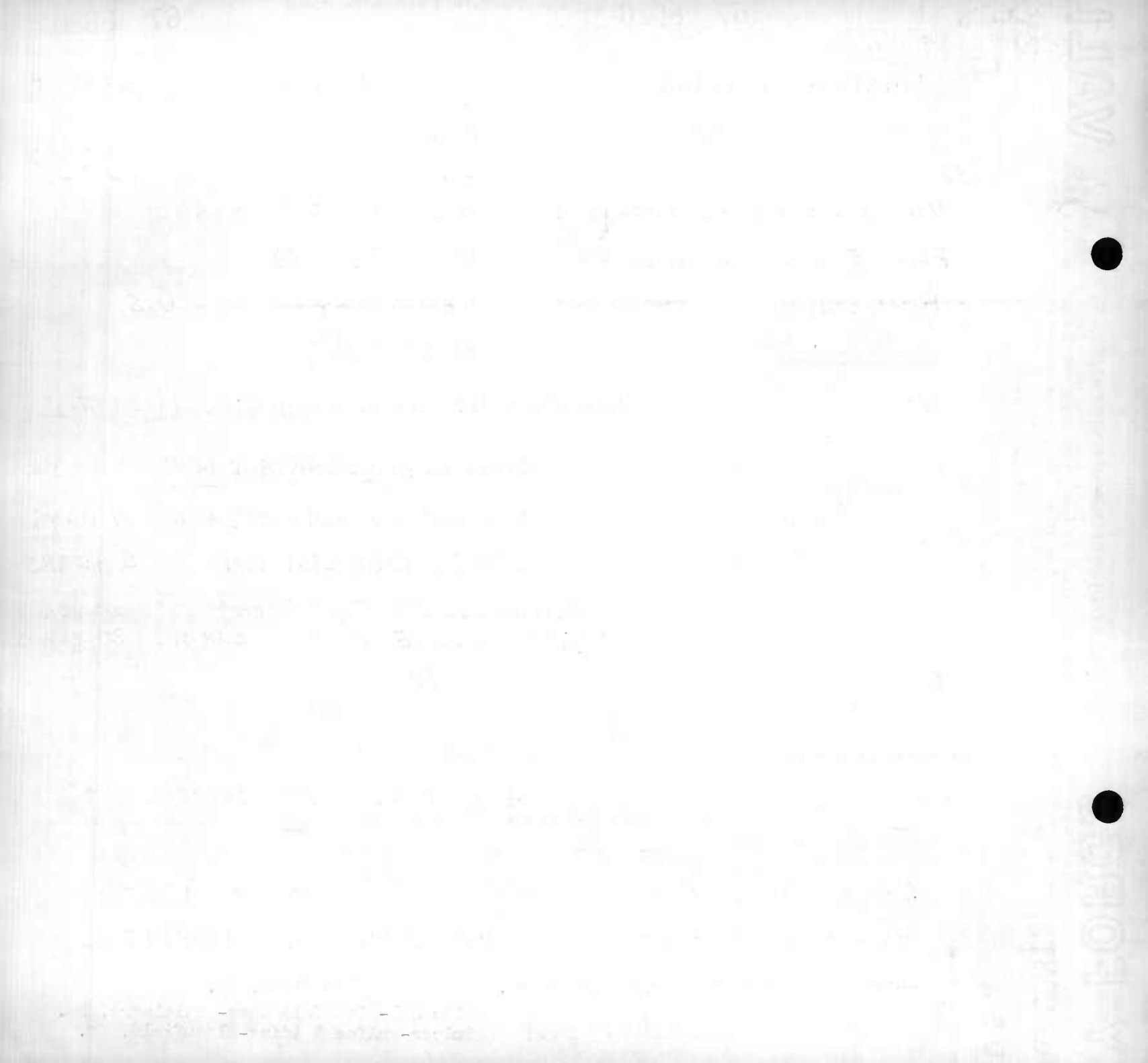
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Large handwritten text block at the bottom of the page, possibly a signature or a detailed note.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8620				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8620	
1. NAME OF DECEASED (Type or Print) MARTHA H. HAYS				2. DATE AND HOUR OF DEATH 9-7-67 12:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) 206 LAMBETH ROAD			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-21-77	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JAMES B. HAYS XXXXXXXXXX			14. MOTHER'S MAIDEN NAME SIDNEY ANN NEALE XXXXXXXXXX		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. UNKNOWN			17. INFORMANT ADDRESS HOSPITAL ADMISSION HISTORY				
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROSIS, GENERALIZED 20 YEARS HYPERTENSIVE CARDIOVASCULAR DIS. 30 YEARS				(A) CEREBROVASCULAR ACCIDENT 4 DAYS DUE TO (B) PULMONARY EMBOLIZATION 4 DAYS DUE TO (C) ATRIAL FIBRILLATION 5 YEARS			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 27 1967 to SEPTEMBER 7 1967 , that (I) (we) last saw the deceased alive on SEPTEMBER 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bruce E. Cathey				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-7-67	
23C. PHYSICIAN'S NAME (Type) BRUCE E. CATHEY				23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/10/67		24C. NAME OF CEMETERY or CREMATORY Maple Grove Cem.		24D. LOCATION (City, town, or county) (State) Bloomfield, Ky.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Bruce E. Cathey		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home- Baltimore, Md. Spicer-McAfee & Adams-Bloomfield, Ky.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8621

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

N.

BRUCK

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1967

2:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4002 Wilkey Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 14, 1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Butcher

10B. KIND OF BUSINESS OR INDUSTRY

Meats

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Bruck

14. MOTHER'S MAIDEN NAME

Magdalena Hepp

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W 2,

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary Bruck 4002 Wilke Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/7/67

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Colgate, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 11 1967

Ullrich Funeral Home 4210 Belair Road.

1953

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Oct. 11, 1953

London

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8622				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8622	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>WINN, WILLIAM</i>				2. DATE AND HOUR OF DEATH <i>4:28 PM 9/7/67</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 MERCY HOSPITAL</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MD.</i>		B. COUNTY <i>CITY (Balt)</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
				D. STREET ADDRESS (If rural, give location) <i>3900 FORRESTER AVE</i>			
5. SEX <i>M</i>	6. RACE <i>Cauc</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>8/22/1890</i>	9. AGE (In years lost birthday) <i>77</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired (?)</i>			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>ARIZONA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>WINN, RONALD S.</i>				14. MOTHER'S MAIDEN NAME <i>TUTON, EMMA J.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>MRS MARIE L. WINN 3900 FORRESTER AVE</i>		
18. <i>332 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Undetermined</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
(B) <i>Central Thrombosis</i> DUE TO				(C) <i>4 days</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 3</i> 19 <i>67</i> to <i>Aug 7</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Aug 7</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>M. Susan Bollinger</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/7/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. SUSAN BOLLINGER</i> M.D.				23D. ADDRESS <i>MERCY HOSP</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9/11/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>HOLY REDEEMER</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>UGERICH FUNERAL HOME 4210 BELAIR</i>			

Sept 27
1888
C. C. Brown

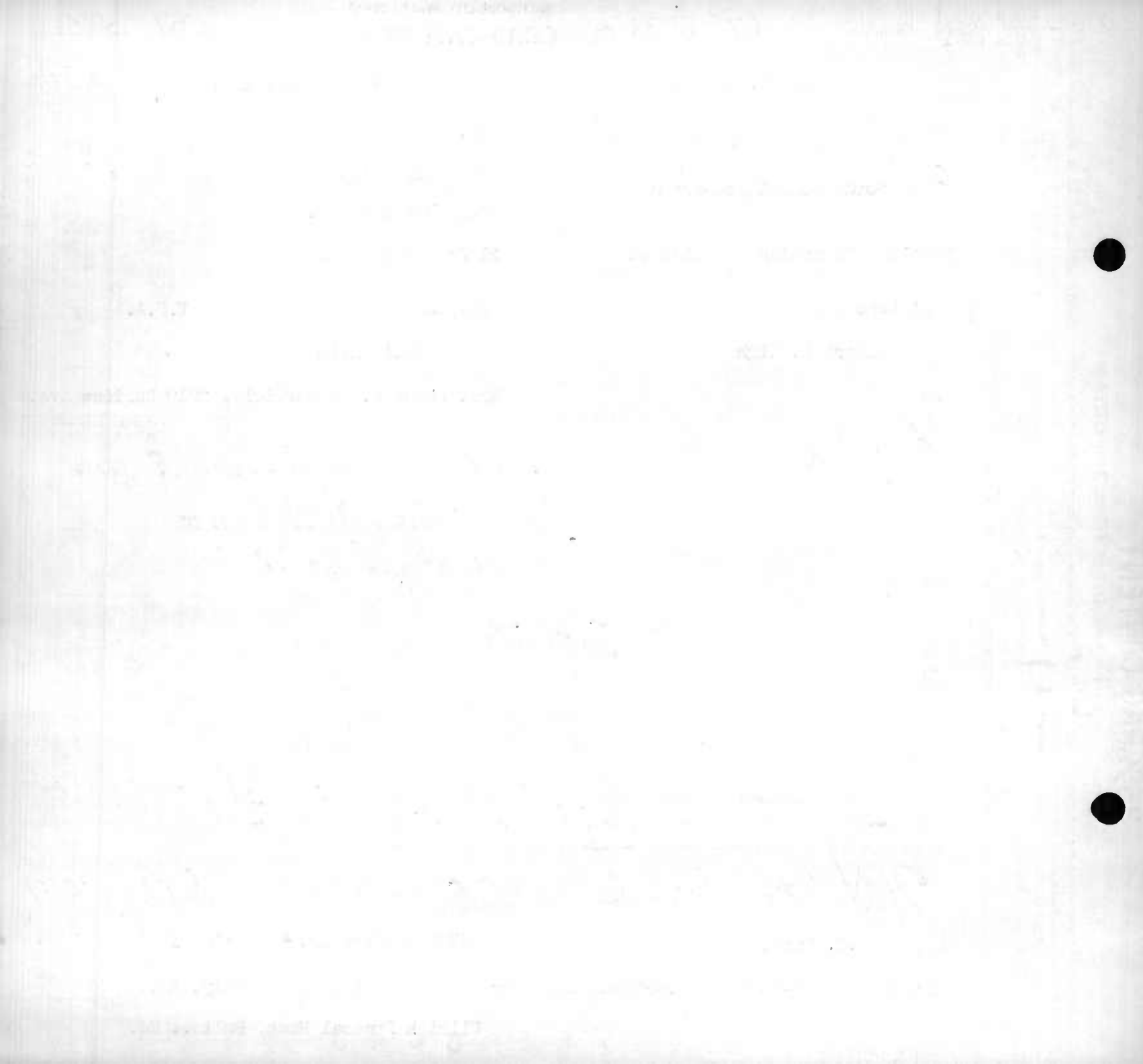
M. G. H.
H. G. H.
H. G. H.

Sept 28
1888
C. C. Brown

Sept 29
1888
C. C. Brown
H. G. H.
H. G. H.
H. G. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8623	
BIRTH NO. 67 8623		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SOPHIA V. LE SAGE		2. DATE AND HOUR OF DEATH 7 September 1967 5:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gpuld Convelesce-arium		A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City D. STREET ADDRESS (If rural, give location) 2910 Harview Ave.			
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED widowed	8. DATE OF BIRTH 21 Jan 1892	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Albert E. High		14. MOTHER'S MAIDEN NAME Katie Heim			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Ehrma L. Butterfield, 2910 Harview Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 527.1 I Pulmonary emphysema		CAUSE OF DEATH Chronic Myocarditis GRADE III Pulmonary fibrosis		INTERVAL BETWEEN ONSET AND DEATH 8 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Hepatomegaly					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 19 57 to Sept. 7 , 19 67 , that (I) (we) last saw the deceased alive on Sept. 6 , 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE H.V. Harbold M.D.				23B. DATE SIGNED Sept. 7, 1967	
23C. PHYSICIAN'S NAME (Type) H.V. Harbold		23D. ADDRESS 4706 Harford Rd. 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 9-9-67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore County, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967			
25B. NAME OF REGISTRAR Philip S. [unclear]		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home, Balto., Md.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GERALD

HUEY

2. DATE AND HOUR PRONOUNCED DEAD

September 3, 1967 10:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

744 Aldworth Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 6, 1924

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Route salesman

10B. KIND OF BUSINESS OR INDUSTRY

Bakery

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Samuel Huey

14. MOTHER'S MAIDEN NAME

Lela Meekins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes W W 2 W W 2

16. SOCIAL
SECURITY NO.

218-16-1052

17. INFORMANT

ADDRESS

Mrs. Irma Huey 1705 Manning Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/4/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/7/67

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Colgate, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

Robert E. Falsberg

24C. FUNERAL DIRECTOR

Ullrich Funeral Home Dundalk, Md.

ADDRESS

ORIGINAL

49-50-07IN

FUNERAL DIRECTOR: IMPORTANT

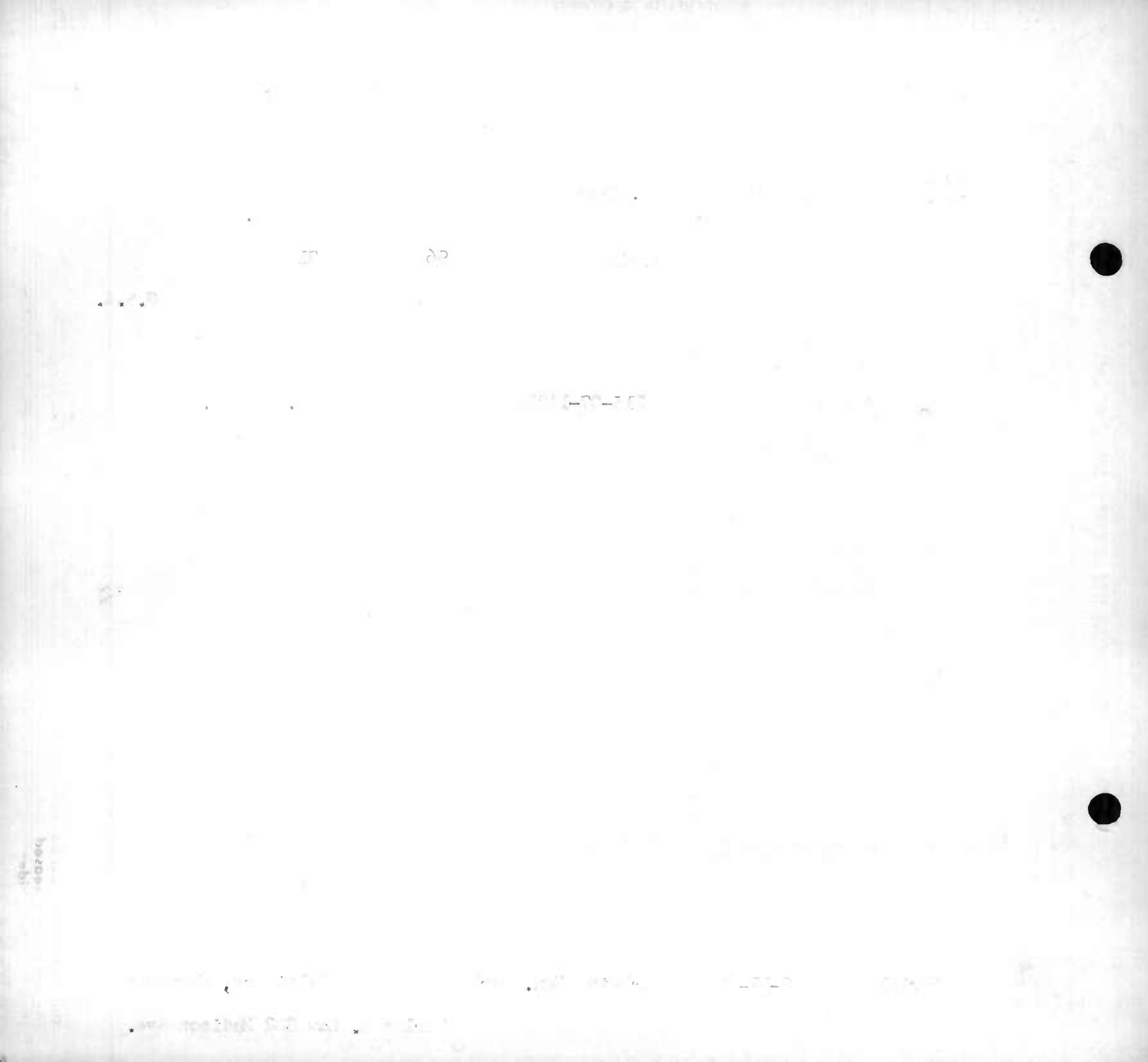
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8625		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8625	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Winfield, Elizabeth Queen		2. DATE AND HOUR OF DEATH 9/7/67 9:25 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		1303	
		D. STREET ADDRESS (If rural, give location) 2308 DRUID PARK DR 21215			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED DIVORCED	8. DATE OF BIRTH 10-8-11	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MARION WINFIELD		14. MOTHER'S MAIDEN NAME DRAKE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-22-3854		17. INFORMANT ADDRESS BCH: RECORDS 4940 EASTERN AVENUE 21224	
18. 331X+1174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CVA DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CVA DUE TO INTERVAL BETWEEN ONSET AND DEATH 17 hr			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Metastatic Ca of uterus			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4:30 A.M. 9-7-1967 to 9:25 PM 9-7-1967 , that (2) (we) last saw the deceased alive on 9:25 9-7-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roy S. Weiner		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-7-67	
23C. PHYSICIAN'S NAME (Type) DR. ROY S. WEINER		23D. ADDRESS Baltimore City Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Charles R. Law		25D. ADDRESS 802 Madison Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8626				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8626	
1. NAME OF DECEASED (Type or Print) James Williams				2. DATE AND HOUR OF DEATH September 6, 1967 11:00p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing & Conv. Center				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 329 Schroeder St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/5/96	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Williams				14. MOTHER'S MAIDEN NAME Eliza Griffin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-07-2498A		17. INFORMANT ADDRESS Bolton Hill Nurs. & Conv. Center		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 010X I Tuberculosis Meningitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/6 1967 to 9/6 1967 , that (I) (we) last saw the deceased alive on 9/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alvin Thompson				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/7/67	
23C. PHYSICIAN'S NAME (Type) Alvin Thompson				23D. ADDRESS 1856 N. Wolfe St Baltimore 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8627				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8627	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
TRECIAK, ALBERT FERDINAND				September 6, 1967		4:55 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS				A. STATE Maryland			
				B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3702 Lyndale Avenue #13			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7/29/11	9. AGE (In years last birthday) 56 yrs.	10. If Under 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair Man		10B. KIND OF BUSINESS OR INDUSTRY Gen. Motors Chevrolet Balto., Md.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew H. Treciak				14. MOTHER'S MAIDEN NAME Katherine Stacharowski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 215-14-8982		17. INFORMANT Frances Treciak, wife, above		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO Cardiovascular Hypertensive Disease (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from April 16, 1967 to Sept. 6, 1967, that (I) (we) last saw the deceased alive on August 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Michael J. Dausch				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept. 7, 1967	
23C. PHYSICIAN'S NAME (Type) Dr. Michael Dausch				23D. ADDRESS 4636 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/67		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR R. A. E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 18316 Prohms Lane #13	

Common Thistle

In the low-lying fields

46 - 1940

1940 - 1941

Michael J. Linn

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. E-430		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8628	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LEONARD ELLIOTT		2. DATE AND HOUR OF DEATH 10:30 AM 9/7/67		10.30 A	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY X			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		10-02	
		D. STREET ADDRESS (If rural, give location) 922 Ashland Court 21202			
5. SEX male	6. RACE White	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/30/88	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Fisherman		10B. KIND OF BUSINESS OR INDUSTRY Oysters and fish crabs		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ? Elliott		14. MOTHER'S MAIDEN NAME Sarah	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-2020		17. INFORMANT ADDRESS Records: BCM-4940 Eastern Avenue 21224	
18. 002,1/1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) RESP. INSUFF DUE TO		INTERVAL BETWEEN ONSET AND DEATH Tbc	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/26/67 19 67 to 9/7 19 67 , that (I) (we) last saw the deceased alive on 9/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stewart Leibowitz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-7-67	
23C. PHYSICIAN'S NAME (Type) Stewart Leibowitz		M.D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Baltimore, Md.		24E. TRUNKS Trunks Trumps Mill Road		24F. ADDRESS 21216	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Stedman		25C. FUNERAL DIRECTOR G. Howard Strong 3207 West North Ave.	

4/25/67 - Resp. Encl. due to T.B.

See letter in File from BCT Rev. of

ge. ^{Statistics} American Bldg

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8629 CERTIFICATE OF DEATH					Registered No. 67 8629				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Anna Vanek					2. DATE AND HOUR OF DEATH Sept. 8, 1967 5.35 p.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines, Belvedere 90					A. STATE Maryland B. COUNTY Baltimore C				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Randallstown 21133 53-00				
D. STREET ADDRESS (If rural, give location) 8605 Gray Fox Road									
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED Married		8. DATE OF BIRTH Aug. 1, 1885	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank Sik				14. MOTHER'S MAIDEN NAME Frankes Merta					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT 8605 Grey Fox Rd. Frank Vanek Sr. Randallstown, Maryland			
18. 194X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Carcinoma of thyroid DUE TO (B) metastases to left lung. DUE TO (C) Pneumonia + Carcinoma of thyroid. Carcinomatous. INTERVAL BETWEEN ONSET AND DEATH Prior to June = '67 June = 1967				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 4 - 1967 to 9-8-1967 , that (I) (we) last saw the deceased alive on 9-2-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Bernard J. Cohen (for Dr. C. Cohen.)					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) BERNARD J. COHEN.					23D. ADDRESS The Maryland Agr. 3501 St. Paul St.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Hall		25C. FUNERAL DIRECTOR 8728 Liberty Rd. Randallstown Md					

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21. (continued)

Вариант 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8630	
67 8630				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type in full)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
MILLENBERG LAURA Millenburg		ST AGNES HOSPITAL FULL NAME OF (If not in hospital or institution, give street address or location) CATON & WILKENS AVE. BALTO 21229 MD		MARYLAND A. STATE B. COUNTY	
5. SEX FEMALE		6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 02/14/89	9. AGE (In years lost birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ADM. SLIP ST AGNES HOSP.	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Carcinoma of the colon</i> (A) DUE TO <i>with multiple metastasis</i> (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPT. 5 19 67 to SEPT. 7 19 67 , that (X) (we) last saw the deceased alive on SEPT 7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Arnold</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-7-67	
23C. PHYSICIAN'S NAME (Type) <i>Paulino D. Vassallo,</i>		M.D. ADDRESS ST. AGNES HOSP; CATON & WILKENS AVES.		21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR <i>Robert E. Hubbard</i>	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		ADDRESS			

ST. AGNES HOSPITAL
374 WILKINS AVE.
DARTMOUTH, N.H.

THE HOSPITAL

ST. AGNES HOSPITAL
DARTMOUTH, N.H.

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DARTMOUTH, N.H.

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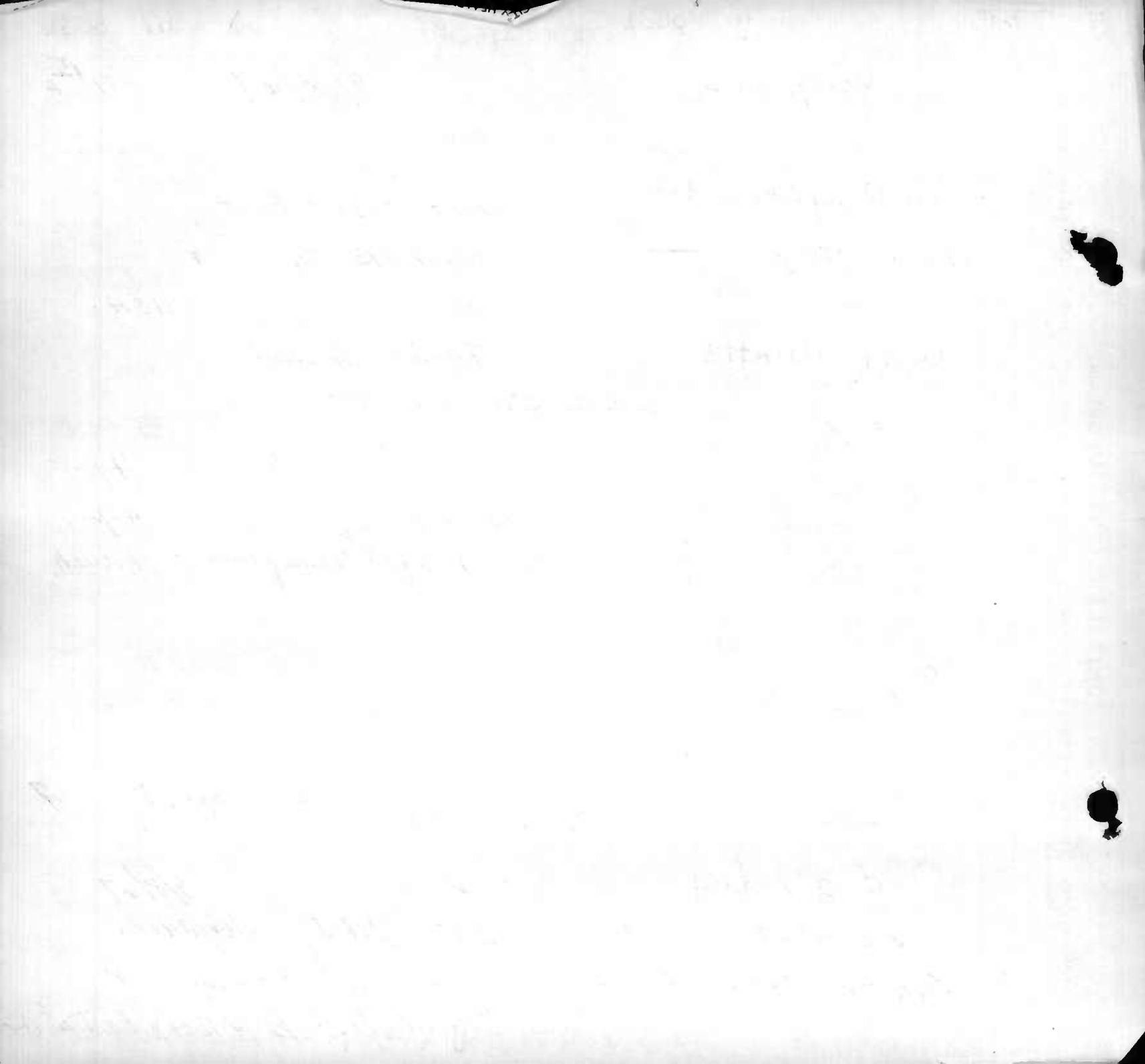
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ST. AGNES HOSPITAL
DARTMOUTH, N.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8631		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8631	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Young, Ada</i>		2. DATE AND HOUR OF DEATH <i>9/8/67</i> <i>11:15</i> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington</i> <i>607 Pennsylvania Ave</i>		A. STATE <i>md.</i> B. COUNTY <i>X</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1029 Wilnot Court</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify)	8. DATE OF BIRTH <i>NOV. 14, 1893</i>	9. AGE (In years last birthday) <i>74</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balt.</i>	
13. FATHER'S NAME <i>Will WATTS</i>		14. MOTHER'S MAIDEN NAME <i>Fannie Brown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-07675-D</i>		17. INFORMANT <i>Chart</i>	
18. <i>331X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>General Anterior Sclerosis</i>		<i>4 yrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>ASC D</i>		<i>4 yrs.</i>	
		(C) <i>Recent Hpt. CVA</i>		<i>1 week</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1963</i> <i>Sept. 8</i> <i>1963</i> to <i>Sept. 8</i> <i>1963</i> that (I) (we) last saw the deceased alive on <i>9/8/1</i> <i>1963</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E E Holt</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9/8/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>E E Holt</i>		23D. ADDRESS M.D. <i>3715 Liberty Heights Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>9/13/67</i>	24C. NAME of CEMETERY or CREMATORY <i>Balt. National</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. County, Md.</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 11 1967</i>		25B. NAME OF REGISTRAR <i>Philip E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Joseph J. Locke</i>	
				ADDRESS <i>1304 N. Central Ave</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300		67 8632		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8632	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARGARET E. BODE				2. DATE AND HOUR OF DEATH September 5, 1967 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Century Nursing Home 102 N. Poca St. Baltimore, 21201, Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 407 S. Macon St. # 21224.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept., 3, 1893	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Collins				14. MOTHER'S MAIDEN NAME Mary Gebhardt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT William C. Bode 4023 St. Augustine Dr. Balto., Md.			
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio-Vascular Failure Ant CVA D. Gen. Arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 67 to Sept 5 1967 , that (I) (we) last saw the deceased alive on Sept 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept 7 1967	
23C. PHYSICIAN'S NAME (Type) Willard Applefeld				23D. ADDRESS 5901 Park Heights Ave., Balto., 21207, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-8 -67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Elkridge, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR R. A. E. Johnson		25C. FUNERAL DIRECTOR Charles J. Seiler			
001 S. Conkling St. Balto., 21224, Md.							

July 1, 1906

July 1, 1906

Dear Sir,

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 28th inst.

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,

Very respectfully,

Yours faithfully,

Yours faithfully,

Wm. H. ...
...

Wm. H. ...
...

Wm. H. ...
...

Very respectfully,

Very respectfully,

Yours faithfully,

Yours faithfully,

Wm. H. ...
...

Wm. H. ...
...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8633				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8633	
1. NAME OF DECEASED (Type or Print) JAY G EASTON				2. DATE AND HOUR OF DEATH Sept 6, 1967 7:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2805 Miles Ave				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-07 D. STREET ADDRESS (If rural, give location) 2805 Miles Avenue			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Sept 5, 1896	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckers Helper			10B. KIND OF BUSINESS OR INDUSTRY Southern Motors		11. BIRTHPLACE (State or foreign country) md.		
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-01-6269		17. INFORMANT Helen L. Easton		
			ADDRESS 2805 Miles Ave.				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 9-9-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-6-1936 to 9-6-1967 , that (I) we last saw the deceased alive on 8-15-1967 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.							
23A. SIGNATURE Reuben Hoffman				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-9-67	
23C. PHYSICIAN'S NAME (Type) REUBEN HOFFMAN		23D. ADDRESS 846 W. 36th St.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Sept 9, 1967	24C. NAME OF CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Paul E. Finkbeiner			
				ADDRESS 3615 Chestnut Ave			

1. 1.

1750-1800

1800-1850

FUNERAL DIRECTOR: IMPORTANT

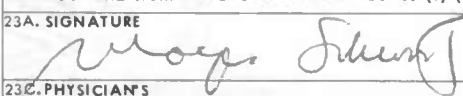
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

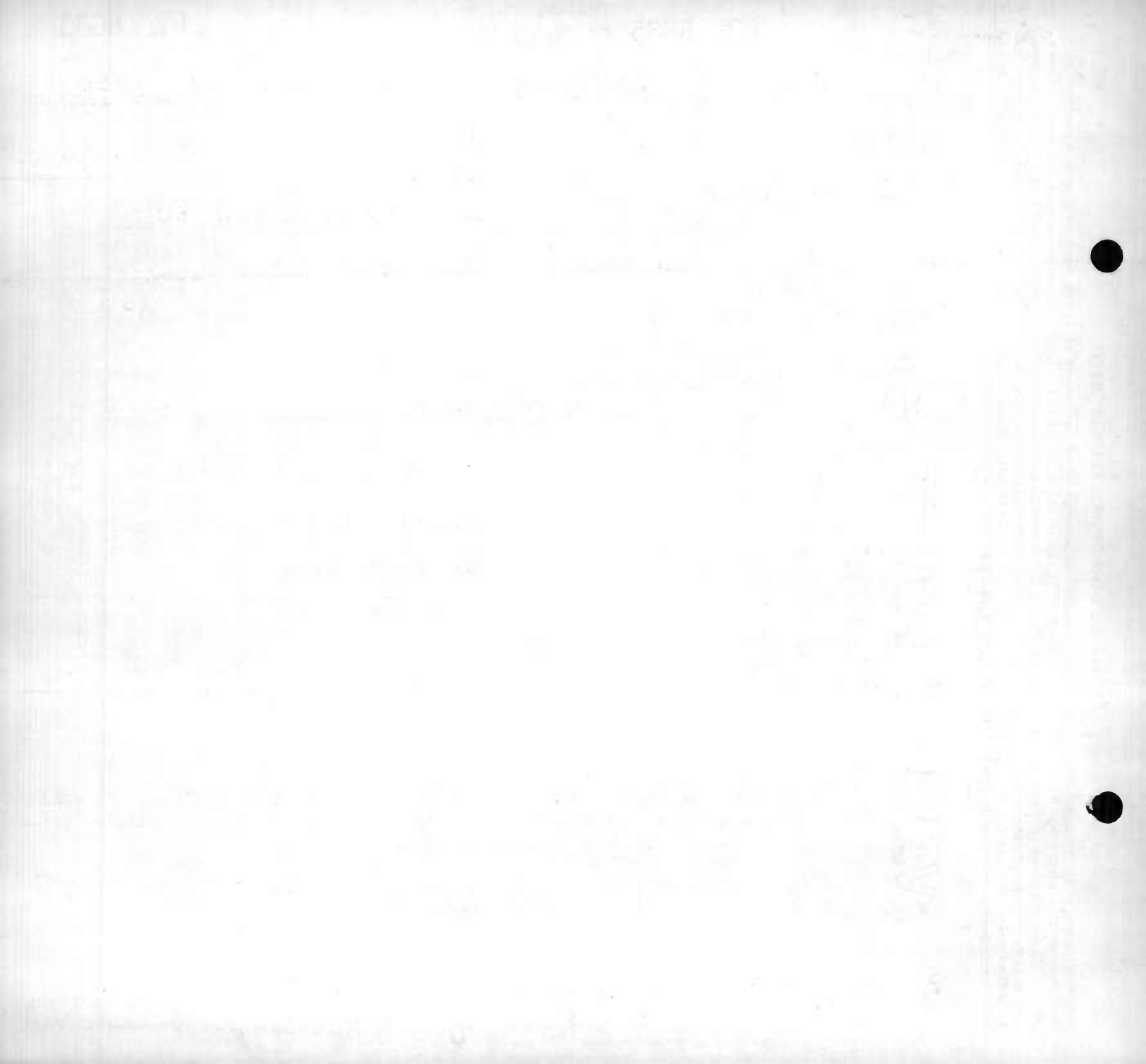
BALTIMORE CITY HEALTH DEPARTMENT										
67 8634 CERTIFICATE OF DEATH					Registered No. 67 8634					
BIRTH NO. 67 8634					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) BAKER, EMMA					2. DATE AND HOUR OF DEATH 9/7/67 11:38 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE, INC. 42					A. STATE MARYLAND B. COUNTY					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-31					
					D. STREET ADDRESS (If rural, give location) 5406 LYNVIEW AVE.					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1/21/00	9. AGE (in years last birthday) 67	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME HARVEY ISSAC APPEL					14. MOTHER'S MAIDEN NAME SYLVIA APPEL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS MRS SYLVIA BENNETT 3401 LYNVIEW AVE				
18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE RENAL FAILURE GASTROINTESTINAL HEMORRHAGE CHRONIC & DIFFUSE CEREBROVASCULAR INSUFFICIENCY					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN 2 years.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 9/6 19 67 to 9/7 19 67 , that (I) (we) last saw the deceased alive on 9/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Ronald Schachar M.D.					23B. DATE SIGNED 9/7/67			23C. PHYSICIAN'S NAME (Type) RONALD SCHACHAR		
23D. ADDRESS SINAI HOSPITAL OF BALTIMORE										
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 9/8/67		24C. NAME OF CEMETERY OR CREMATORY Bnai Israel			24D. LOCATION (City, town, or county) (State) BALTO MD		
25A. DATE RECEIVED BY HEALTH DEPT. 9/8/67			25B. NAME OF REGISTRAR Robert E. Schachar			25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc			ADDRESS Garmers	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8635	
BIRTH NO. 67 8635		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MORRIS GOLDSCHIEDER		2. DATE AND HOUR OF DEATH 7 SEPTEMBER 1967 1930 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 421 SINAI HOSP		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-05	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL. EST.		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH MAY 1985 82	
13. FATHER'S NAME BORYL		14. MOTHER'S MAIDEN NAME FRIEDA		9. AGE (In years last birthday) 82	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-16-6935A		17. INFORMANT WIFE	
18. 7-20-01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) PNEUMONIA - CONG. HT. FAILURE		5 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ARTERIOSCLEROTIC HEART DIS.			
		(C) GENERALIZED ARTEROSCLEROSIS			
II		PARKINSON'S DISEASE			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 9/6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 SEPT 1967 to 7 SEPT 1967 , that (I) (we) last saw the deceased alive on 7 SEPT 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7 SEPT. 67	
23C. PHYSICIAN'S NAME (Type) MORRIS GOLDSCHIEDER		23D. ADDRESS M.D. SINAI HOSPITAL - BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/67		24C. NAME of CEMETERY or CREMATORY Oh Knesseth Chel	
24D. LOCATION Balto		(City, town, or county)		(State) MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Sylvan S. Lissman, Inc	
				ADDRESS Garrison, MD	



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE MEEKINS

2. DATE AND HOUR PRONOUNCED DEAD

September 6, 1967 7:00 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF HOSPITAL OR INSTITUTION
 (If not in hospital or institution, give street address or location)
 10-11-67
 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

DORCHESTER Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Cambridge

59-13

D. STREET ADDRESS (If rural, give location)

700 WASHINGTON STREET

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

DEC. 2, 1921

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

CLARENCE W. MEEKINS

14. MOTHER'S MAIDEN NAME

RHODA LANE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

2/6/45 -- 12/23/45

16. SOCIAL
SECURITY NO.

213-14-1803

17. INFORMANT

ALENE MEEKINS

ADDRESS

CAMBRIDGE, MD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of head

(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

8-19-67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Gunshot wound

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

700 Walnut Street - first floor

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8-19-67 12:35 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self while playing "Russian

Undetermined

Roulette"

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
 resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☒

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 9, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/10/67

23C. NAME of CEMETERY or CREMATORY

BETHEL

23D. LOCATION

(City, town, or county)

CAMBRIDGE, MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 11 1967

SEP 11 1967

SEP 11 1967

CAMBRIDGE, MD.

Letter from M.E.'s office

10-11-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 8637					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 8637				
1. NAME OF DECEASED (Type or Print) Warren, Howard					2. DATE AND HOUR OF DEATH 9-9-67 11 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital BALTO., Md.					A. STATE MD. B. COUNTY BALT.				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-10					D. STREET ADDRESS (If rural, give location) 4000 Dorchester Rd				
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 12-6-05	9. AGE (In years lost birthday) 61 yr.	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME LAURENCE WARREN					14. MOTHER'S MAIDEN NAME SUSIE FITZGERALD				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 29-014115		17. INFORMANT HENRIETTA WARREN		ADDRESS SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES					Cardiac failure			6 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Chronic lung disease				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Fracture (L) hip				
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) yes			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4000 Dorchester Rd, Balt. MD				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 9 3 67 6 PM			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell down on the floor				
22. I certify that (I) (this hospital) attended the deceased from 9-9-67 to 9-9-67 and that (I) (we) last saw the deceased alive on 9-9-67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE V. KIT					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9-9-67	
23C. PHYSICIAN'S NAME (Type) VICKI KIT			23D. ADDRESS Sinai Hosp.						
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-16-67		24C. NAME OF CEMETERY OR CREMATORY Church Cemetery			24D. LOCATION (City, town, or county) Nashville, Tennessee		
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS Hanson Funeral Home 1348 Calhoun St			

21st Hosp. /
Barr. 14

21st
Barr.

21st Hosp. /
Barr. 14

Barr. 21st Hosp. /
Barr. 14

FUNERAL DIRECTOR: IMPORTANT

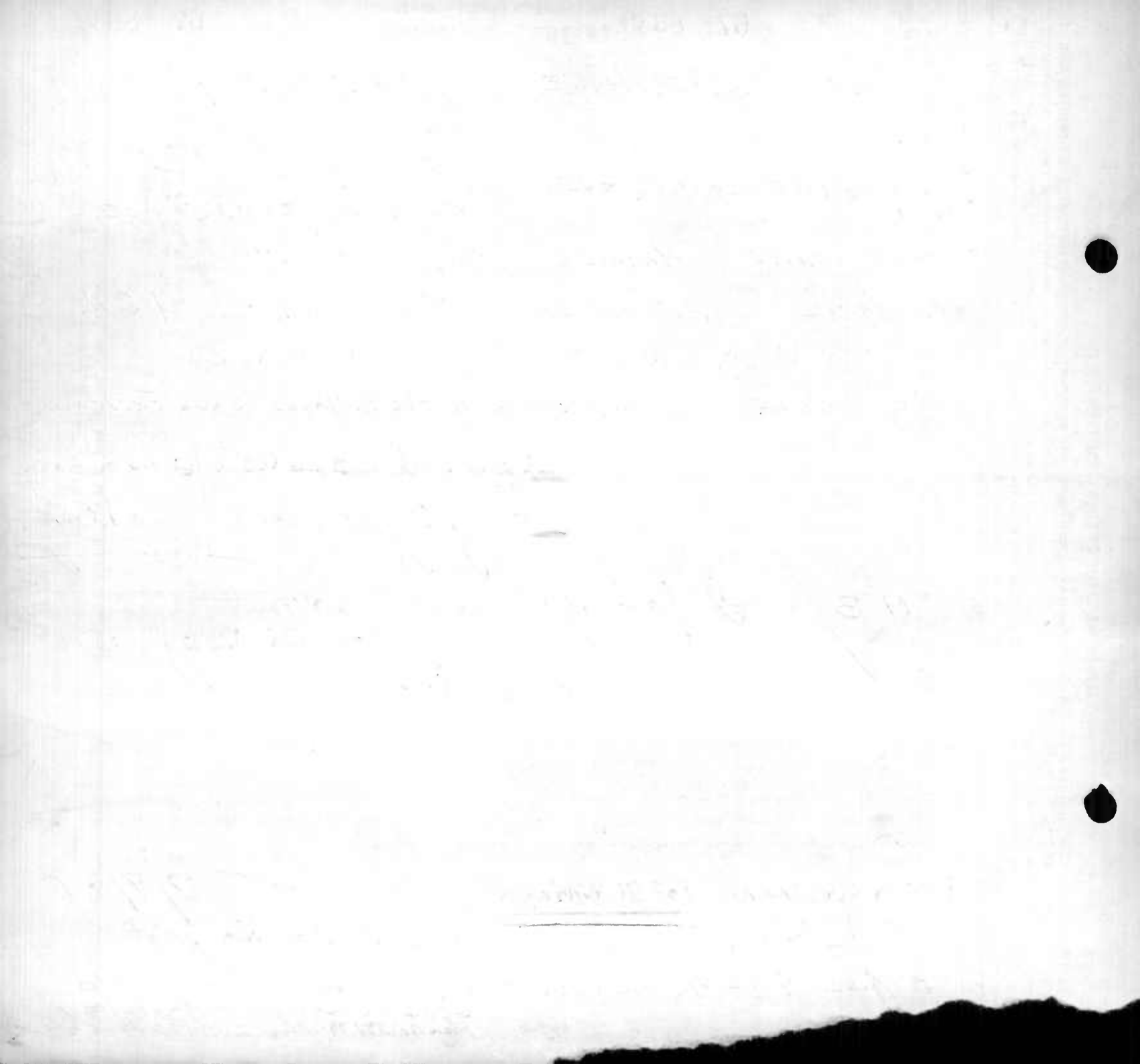
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8638	
BIRTH NO. 67 8638		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROBERT L STEWART Sr		2. DATE AND HOUR OF DEATH 10 SEPT '67 10:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 108 E. MADISON ST.			
5. SEX MALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 13 AUG '11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY TRUCKING		11. BIRTHPLACE (State or foreign country) DURHAM N.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ROBERT H. LEE		14. MOTHER'S MAIDEN NAME LULIA A. STONE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES World War II		16. SOCIAL SECURITY NO. 324-12-1332		17. INFORMANT THERESA STEWART	
18. 356.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) AMYOTROPHIC LATERAL SCLEROSIS		CAUSE OF DEATH (A) AMYOTROPHIC LATERAL SCLEROSIS (B) (C)		INTERVAL BETWEEN ONSET AND DEATH YEARS	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (This hospital) attended the deceased from 8 SEPT 1967 to 10 SEPT 1967 , that (1) (we) last saw the deceased alive on 10 SEPT 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William A. Dear Jr.				23B. DATE SIGNED 10 Sept 67	
23C. PHYSICIAN'S NAME (Type) William A. Dear Jr.				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL	
24D. LOCATION BALTIMORE MD.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967			
25B. NAME OF REGISTRAR Page E. E. E.		25C. FUNERAL DIRECTOR CECIL SCHWAB FUNERAL HOME			

FUNERAL DIRECTOR: IMPORTANT

A certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8639				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8639	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				FRANK LESTER MAYNE			
2. DATE AND HOUR OF DEATH				SEPT. 9, 1967 1:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)				Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
D. STREET ADDRESS (If rural, give location)				3606 Frederick Ave.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
MALE		WHITE		MARRIED		MAY 17 1900	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
67		MECHANIC		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S M maiden name			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		NONE		217-01-6586		ADELE R. MAYNE, 3606 Frederick Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) Cor Pulmonale			
ANTECEDENT CAUSES				(B) Emphysema			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) H.F.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Interval between ONSET AND DEATH			
N.B. / II I did not see patient				late			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		None		NO		for Dr. Wagner	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
DR. G. GROSSMAN FOR DR. WAGNER				9/9/67			
23C. PHYSICIAN'S NAME (Type or Print)				23D. ADDRESS			
G. Grossman				Illegible Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-12-67		Loudon Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
11-10-67				E. L. Schwab		3606 Frederick Ave.	



67 8640

BALTIMORE CITY HEALTH DEPARTMENT

67 8640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN J. GRIGGS, SR.

2. DATE AND HOUR PRONOUNCED DEAD

September 6, 1967 6:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1432 Forest Park Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

Jan. 2/14

9. AGE (In years
last birthday)

58 53

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Printer

10B. KIND OF BUSINESS OR INDUSTRY

Schneidereich & Sons

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Late John Griggs

14. MOTHER'S MAIDEN NAME

Late Grace ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
213-01-2519

17. INFORMANT

Mrs. Anna Griggs

ADDRESS

1432 Forest Park Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 7, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/9/67

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Witzke F. D. - 4101 Edmondson Av.

2

100-100000

AVAILABLE FOR RENT

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8641	
BIRTH NO. 67-17632 67 8641		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SEAN DENNIS DELANEY DELANEY, BABY-BOY-HALL		2. DATE AND HOUR OF DEATH 9-05-67 11:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVES. BALTO., MD. 21229		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, give rural and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5461 CEDONIA AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 9-03-67	9. AGE (In years last birthday) 2	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME JOHN F. DELANEY		14. MOTHER'S MAIDEN NAME ANN MAY DELANEY (MAIDEN NAME UNKNOWN) (Knight) CATON & WILKENS AVES., BALTO., MD HOSPITAL RECORDS- ST. AGNES HOSP.-		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMATION ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Due to Atelectasis Bilateral (B) Due to Pre-maturity (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 3, 19 67 to SEPTEMBER 5, 19 67, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on SEPTEMBER 5, 19 67 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (<input checked="" type="checkbox"/> We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE John K. Weagly				23B. DATE SIGNED 6 September 1967	
23C. PHYSICIAN'S NAME (Type) JOHN K. WEAGLY		23D. ADDRESS ST. AGNES HOSPITAL-CATON AND WILKENS AVES BALTIMORE, MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke B. D.		25D. ADDRESS - 4101 Edmondson Ave.	

Birth Cert. #67-17632

9-28-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8642		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8642	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Schubert, Mrs. Ester M.</i>		2. DATE AND HOUR OF DEATH <i>Sept 9 / 6 / 67 11 30 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>6</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i> <i>48</i>		D. STREET ADDRESS (If rural, give location) <i>1147 W. Hamburg St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>4/19/03</i>	9. AGE (In years last birthday) <i>64</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S. of A.</i>		13. FATHER'S NAME <i>John Wm. Lankau</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Lang</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-03-7984</i>		17. INFORMANT <i>John A. Schubert - Same</i> <i>Chart</i>	
18. <i>296X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>1 Hemorrhagic death</i> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>2 Myeloid metaplasia</i> DUE TO			
		(C) <i>3 Myeloproliferative disorder</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Splenectomy when death</i>			
19A. DATE OF OPERATION <i>3 9/6/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Splenomegaly</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/12/67</i> 19 <i>62</i> to <i>9/6</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9/6</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Gerald D. Buker</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/6/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>GERALD D. BUKER</i>		23D. ADDRESS <i>4101 Edmondson Av.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/11/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Witzke F. D. - 4101 Edmondson Av.</i>	

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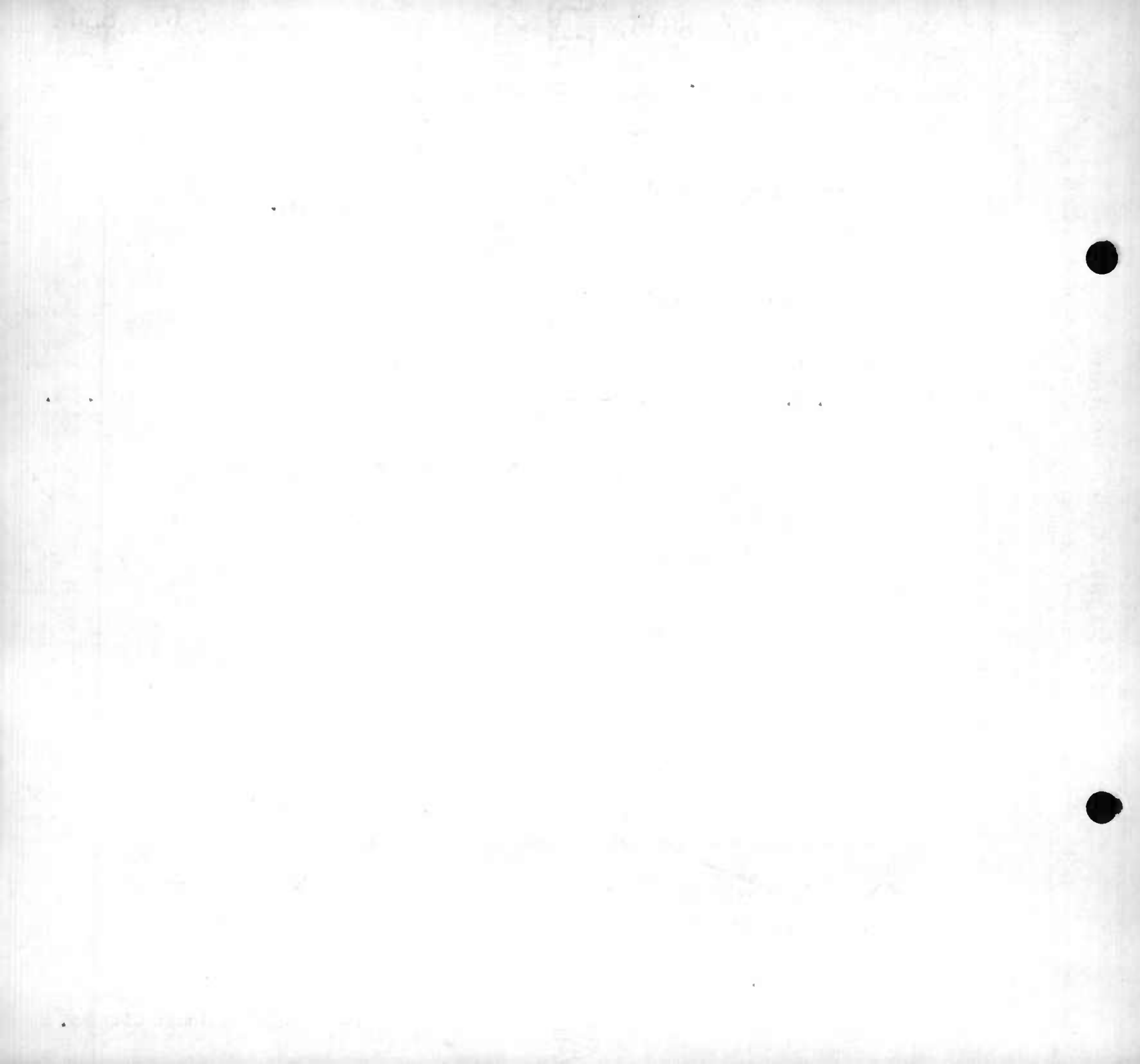
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8643	
BIRTH NO. 67 8643		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Koch David F.</u>		2. DATE AND HOUR OF DEATH <u>9/8/67</u> <u>14</u> ²⁵ <u>P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF INSTITUTION <u>34 Bon Secours Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>4940 Lindsay Road.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1/20/97</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Assembler</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bendix Radio</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
13. FATHER'S NAME <u>Harry Koch</u>		14. MOTHER'S MAIDEN NAME <u>Beckman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W. W. 1</u>		16. SOCIAL SECURITY NO. <u>213-05-7682</u>		17. INFORMANT ADDRESS <u>Mrs Evelyn Koch 4940 Lindsay Rd Balto. Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CORONARY DISEASE</u>		CAUSE OF DEATH (A) <u>CORONARY DISEASE</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>SEPT. 5TH 1967</u> to <u>SEPT 8TH 1967</u> , that (2) (we) last saw the deceased alive on <u>SEPT 8TH 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above: (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>KYE YOUN</u>				23B. DATE SIGNED <u>9/8/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>KYE YOUN</u>				23D. ADDRESS <u>Bon Secours Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept. 12/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Howard County</u>		25C. FUNERAL DIRECTOR <u>Howard County Funeral Home of Harry Witzke</u>	
				ADDRESS <u>Ellicott City Md.</u>	

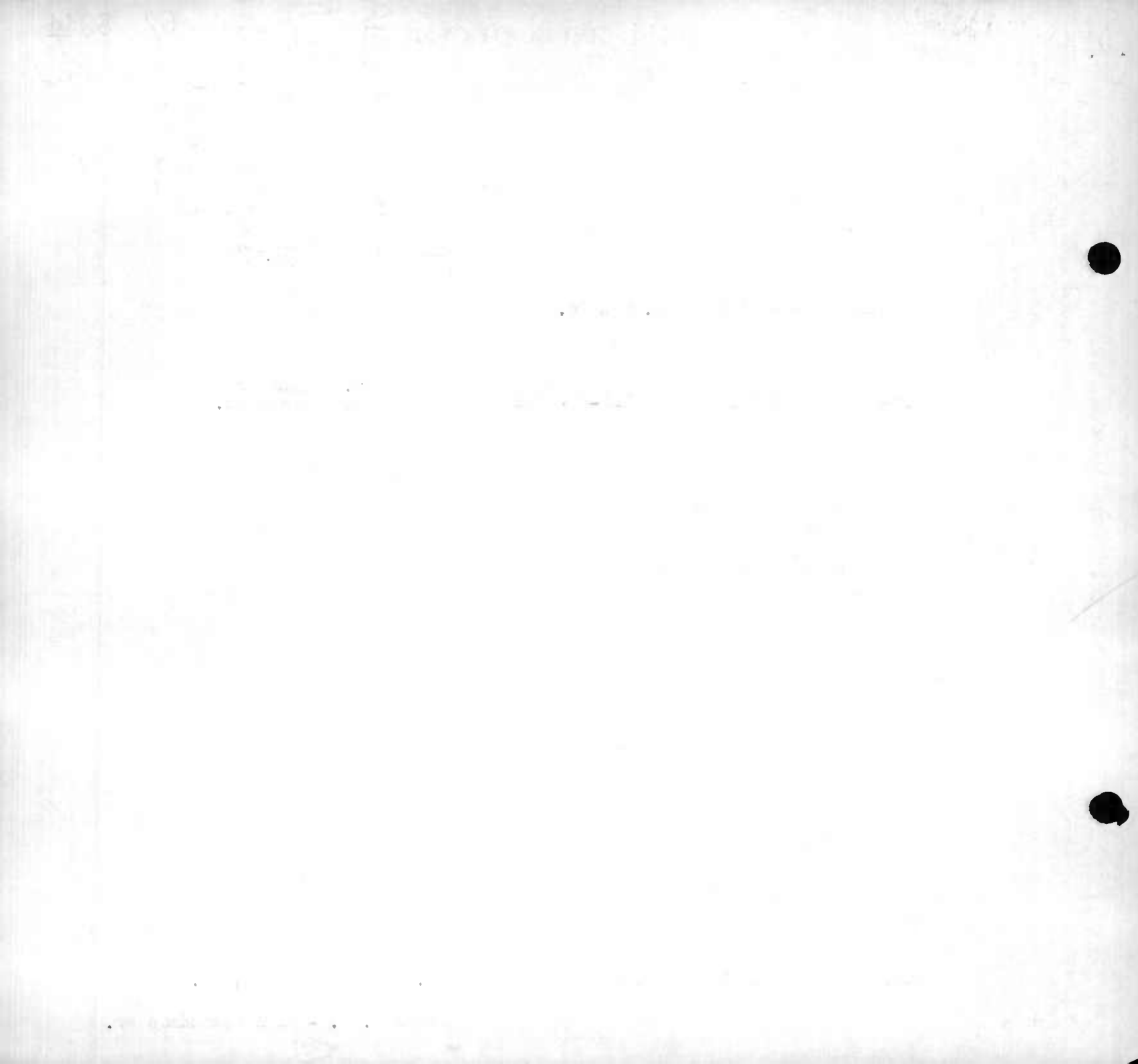
SEP 11 1967



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

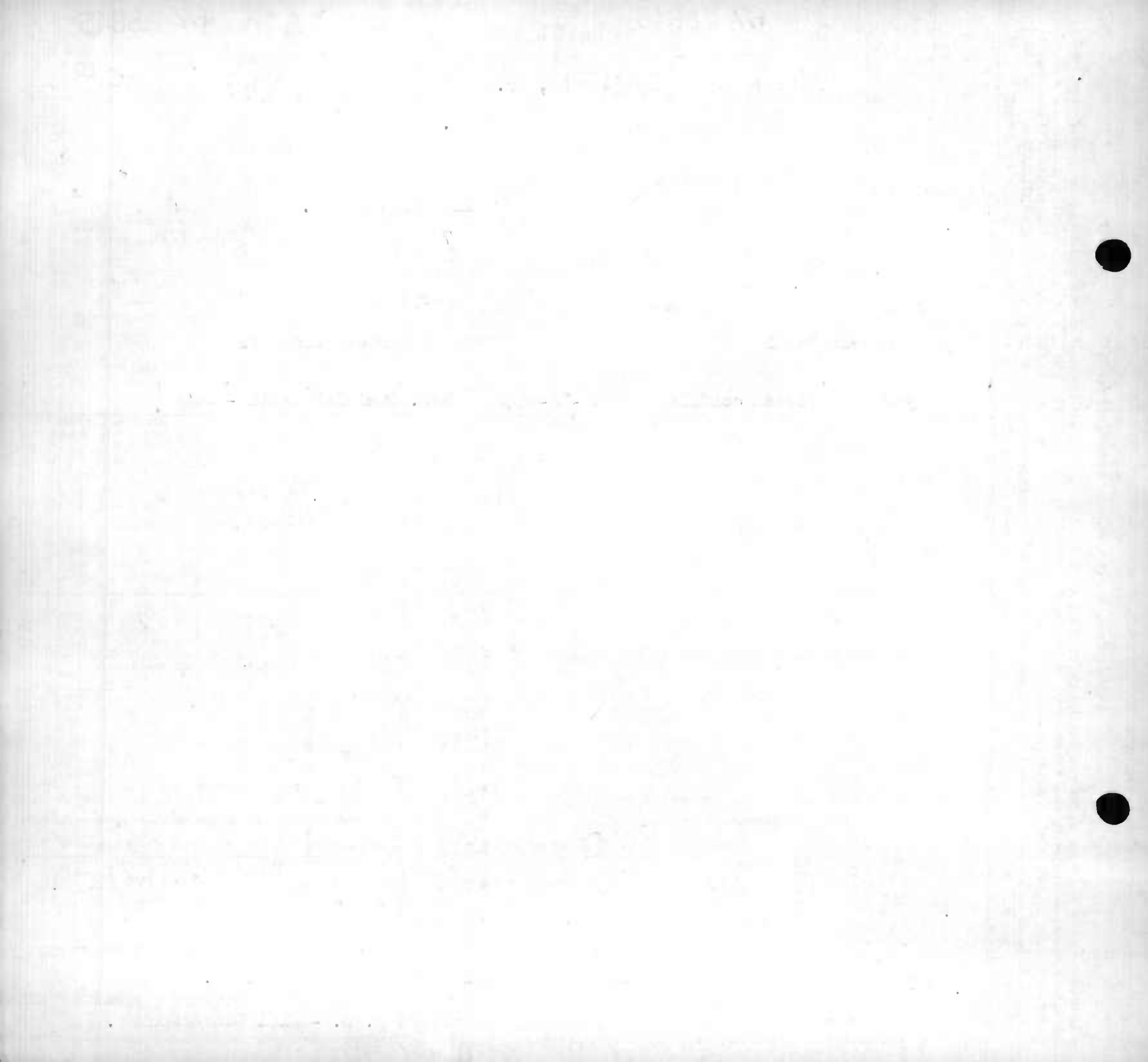
BIRTH NO. 52		67 8644		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8644	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Louis J. Drewanz</i>			
2. DATE AND HOUR OF DEATH <i>8 SEPTEMBER 1967 1:45 A.M.</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>Balto Co</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 53-0021207</i>			
				D. STREET ADDRESS (If rural, give location) <i>1504 BARRETT ROAD</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>9-8-1893</i>	9. AGE (In years lost birthday) <i>74</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Am. Can Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael Drewanz</i>				14. MOTHER'S MAIDEN NAME <i>BARKE</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes W W I</i>		16. SOCIAL SECURITY NO. <i>212-09-5141A</i>		17. INFORMANT <i>Mrs. Regina Drewanz</i>		ADDRESS <i>1504 Barrett Rd.</i>	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>URINARY OBSTRUCTION</i>				(A) DUE TO		<i>MONTHS</i>	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-13</i> 19 <i>67</i> to <i>9-8</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>1:45 AM 9-8</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (d) (did not) view the body after death.							
23A. SIGNATURE <i>Byung Kap Kang</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-8-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>BYUNG KAP KANG</i>				23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/11/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>		25B. NAME OF REGISTRAR <i>Witzke F. D.</i>		25C. FUNERAL DIRECTOR <i>Witzke F. D.</i>		ADDRESS <i>- 4101 Edmondson Av.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8645	
BIRTH NO. 30		67 8645	
M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DOMINICK A. ZANTI, Sr.		2. DATE AND HOUR OF DEATH 9/9/67 10:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 116 Hillvale Rd.	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/2/33
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman		10B. KIND OF BUSINESS OR INDUSTRY B & O RR	9. AGE (In years lost birthday) 33
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Angelo Zanti		14. MOTHER'S MAIDEN NAME Grace Lucchesi	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean conflict		16. SOCIAL SECURITY NO. 216-28-6500	
17. INFORMANT Mrs. Dominick Zanti - Same		ADDRESS	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ACUTE MYOCARDIAL INFARCTION complicated by CARDIAC STANDSTILL. INTERVAL BETWEEN ONSET AND DEATH ONE HOUR	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/9 1967 to 9/9 1967 , that (I) (we) last saw the deceased alive on 9/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.			
23A. SIGNATURE Oscar E. Ferdinandin M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDINI M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/13/67	24C. NAME OF CEMETERY or CREMATORY Baltimore National	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Witzke F. D.		ADDRESS - 4101 Edmondson Av.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8646	
BIRTH NO. 67 8646		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SCOTT, LEROY, S. SR.		2. DATE AND HOUR OF DEATH Sept. 7th 1967 6-40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital 730 Ashburton St. Baltimore 21216			A. STATE Maryland. B. COUNTY 15-47		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21216		
			D. STREET ADDRESS (If rural, give location) 3308 Elgin road AVE		
5. SEX male	6. RACE N COLOUR.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH 3-18-29	9. AGE (In years lost birthday) 38 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Costodian		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Spencer Scott			14. MOTHER'S MAIDEN NAME Ells		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-38-6932	17. INFORMANT Beatrice Scott		ADDRESS 3308 Elgin AVE
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) St. cerebral haemorrhage from hypertension.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 9-6-67 19 to 9-7-67 19, that (I) (we) last saw the deceased alive on 9-7-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.					
23A. SIGNATURE Dr. B. A. Desai				23B. DATE SIGNED 9-7-67	
23C. PHYSICIAN'S NAME (Type) DR. BIPIN. A. DESAI.				23D. ADDRESS Lutheran Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Charles A. Rose	
				ADDRESS 661 W. Balto St	

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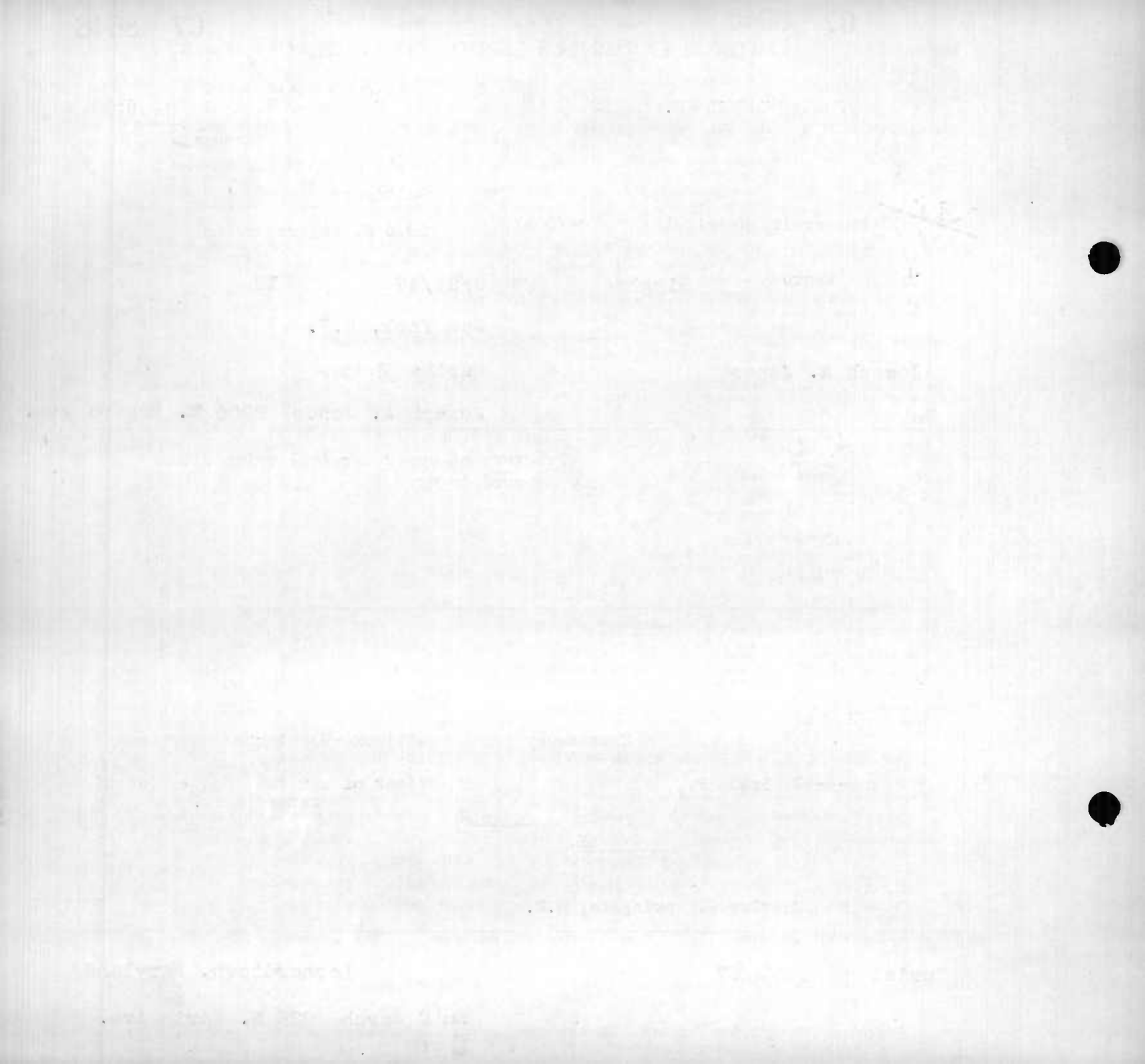
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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		67 8647	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
ROBERT COOPER			September 7, 1967 4:50 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
South Baltimore General Hospital (DOA)			B. COUNTY Baltimore		
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			1004 Creek Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Negro		12/3/23	43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			South Carolina		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert			Rebecca		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					Rebecca Cooper 1314 S. Hanover St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
Intracerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		9/10/67		Mt. Calvary	
23D. LOCATION (City, town, or county)		23E. LOCATION (State)			
Brooklyn, Maryland					
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
SEP 11 1967		Robert E. Taylor, M.D.		Charles A. Rice 661 W. Barre St.	

WACKEY PAPER
ALL DAY PRODIGE

SYSTEM CONTENT

U.S.



67 8649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 8649

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNIE PINDER

2. DATE AND HOUR OF DEATH

SEPT. 9, 1967 2:46 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2917 Fendall Road 21207

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

10-4-1893

9. AGE (in years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Factory Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Dick Jones

14. MOTHER'S MAIDEN NAME

Mary Jones

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-03-6231

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

340.3

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

MENINGITIS

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-7-67 1967 to 9-9-1967
that (I) (we) last saw the deceased alive on Sept. 9 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Raymond J. LaSure

M.D.

Attending ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Sept. 9, 1967

23C. PHYSICIAN'S
NAME (Type)

Raymond J. LaSure

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/14/67

24C. NAME of CEMETERY or CREMATORY

Union Chapel Cem.

24D. LOCATION

(City, town, or county)

Cambridge, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

25B. NAME OF REGISTRAR

Robert E. Jackson

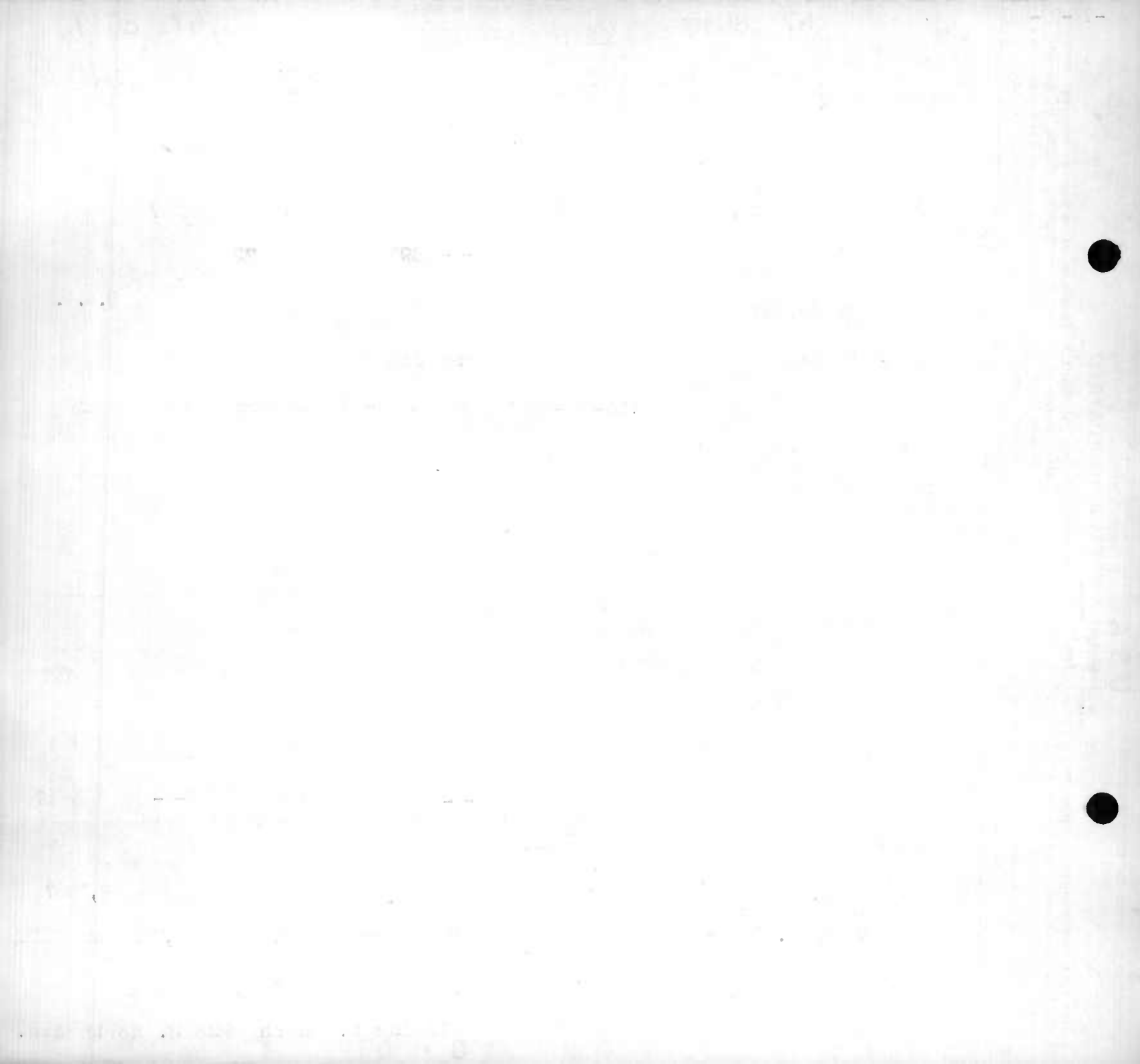
25C. FUNERAL DIRECTOR

William C. March 928 E. North Ave.

ADDRESS

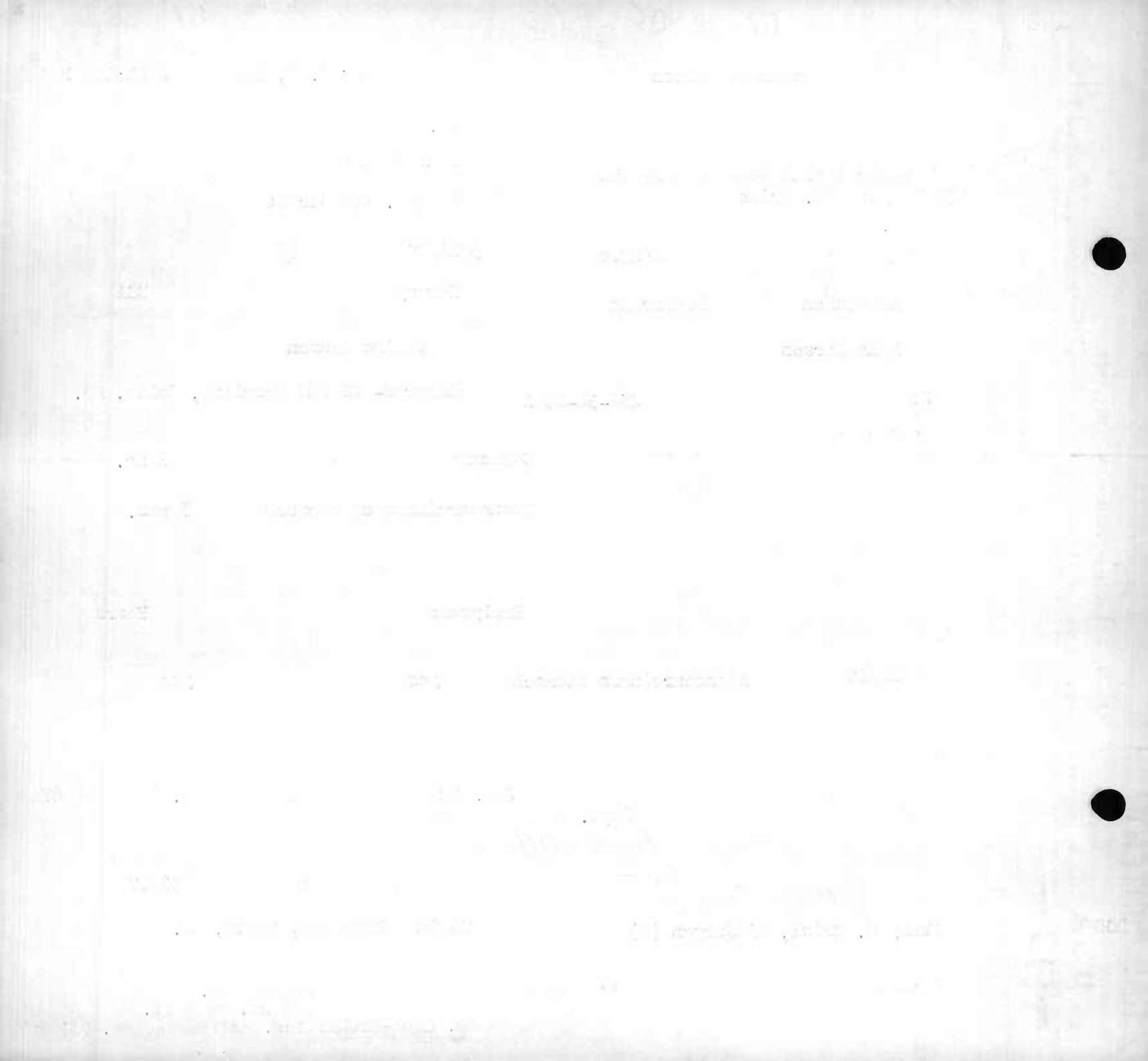
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8650		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8650	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bernhard Larsen		2. DATE AND HOUR OF DEATH Sept. 2, 1967		11:20 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Pk. Drive		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Philadelphia D. STREET ADDRESS (If rural, give location) 2604 S. 4th Street			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5/16/07	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AB seaman		10B. KIND OF BUSINESS OR INDUSTRY Seafaring		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nils Larsen		14. MOTHER'S MAIDEN NAME Tomine Benson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 452-36-2901		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cachexia		CAUSE OF DEATH (A) DUE TO Adenocarcinoma of stomach (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 5 wks.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema		Years	
19A. DATE OF OPERATION 7/28/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma stomach		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? (If in Baltimore City, give exact location)	
21C. WHERE DID INJURY OCCUR? INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from June 22 19 67 to Sept. 2 19 67 , that (1) (we) last saw the deceased alive on Sept. 2 19 67 and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Henry S. Crist		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/5/67	
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surgeon (R)		M.D. 23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9/6/67		24C. NAME OF CEMETERY or CREMATORY Green Mount	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR R. Cook	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md. 21202		25D. ADDRESS 1217 St. Paul St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8651	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 8651 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Louise C. Reinhard			2. DATE AND HOUR OF DEATH 9-9-67 9:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Ardleigh Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 413 E. Lake Ave.		
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 4, 1876	9. AGE (In years last birthday) 91	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Evansville, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Bluhm			14. MOTHER'S MAIDEN NAME Mary Gray		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-32-1612		17. INFORMANT Mrs. Joseph Archer
			ADDRESS 413 E. Lake Ave. Balto.		
18. CAUSE OF DEATH					
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH (A) Date Congestive Heart Failure April 1963 (B) Date Congestive C.V.D. April 1965 (C) Date Dementia June 1963		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-9 1967 to 9-8 1967, that (I) (we) last saw the deceased alive on 9-8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence J. Shuman				23B. DATE SIGNED 9-9-67	
23C. PHYSICIAN'S NAME (Type) Lawrence J. Shuman				23D. ADDRESS 3711 Falls Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/67		24C. NAME OF CEMETERY or CREMATORY Earlham Cemetery	
		24D. LOCATION (City, town, or county) (State) Richmond, Indiana			
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.	
				ADDRESS 1217 St. Paul St.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8652

BIRTH NO. 67 8652

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)ELIZABETH ~~BARTHELME~~ Barthelmes

2. DATE AND HOUR PRONOUNCED DEAD

September 9, 1967 4:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

425 N. Ellwood St. AVE

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 9, 1895

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles A. Born

14. MOTHER'S MAIDEN NAME

Mary Waechter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

425 N. Ellwood St. Ave.
August J. Barthelmes Baltimore, Md. 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Street

On beltway at Rt. 40

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 9 67 12:56 p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject was passenger in auto-auto
collision

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept. 9 67

23C. NAME of CEMETERY or CREMATORY

Oak Lawn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md. Balto. Co.

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

Robert S. Fisher

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Towson, Towson, Md.

ADDRESS

H. 650

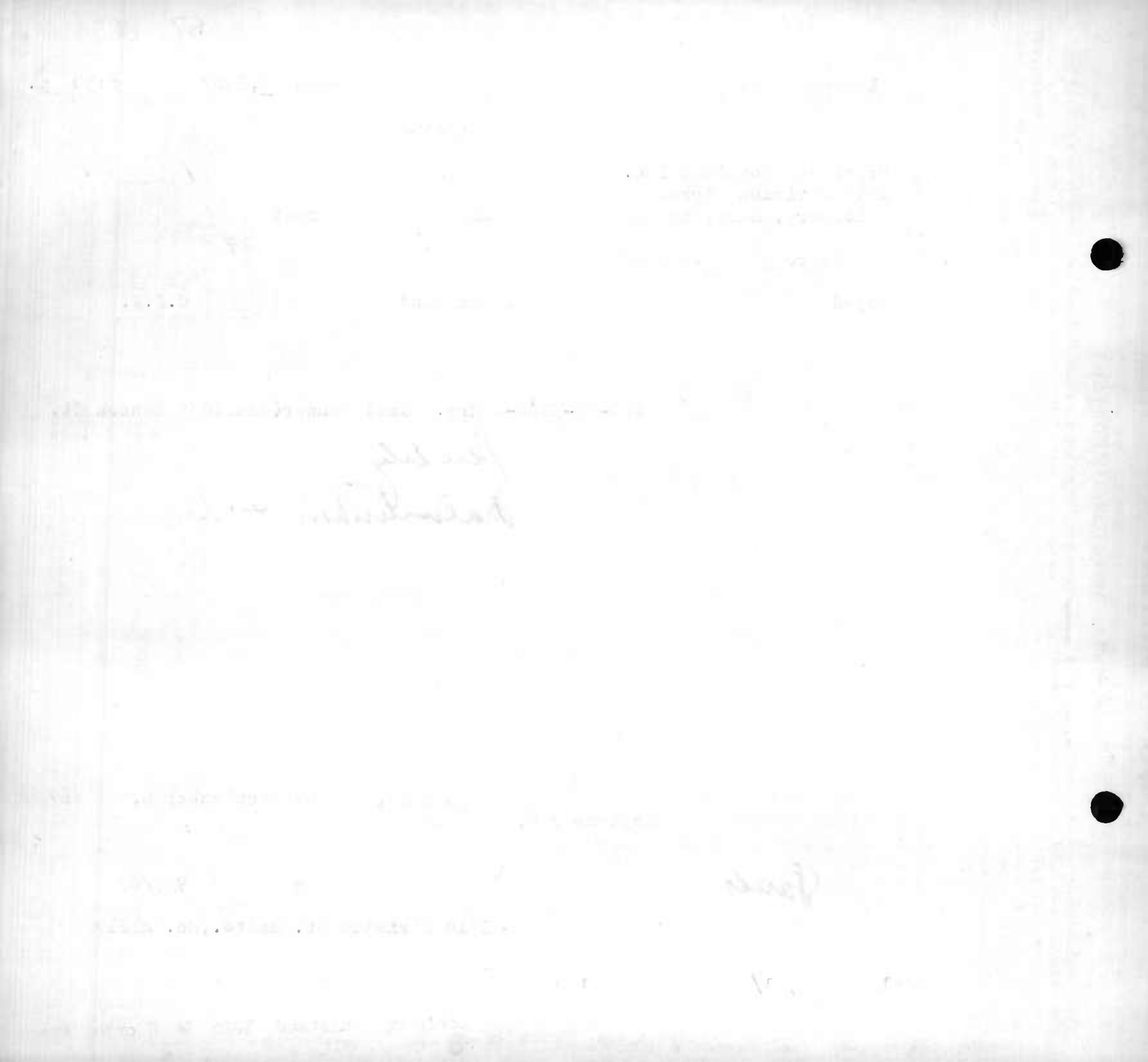
67 8653		BALTIMORE CITY HEALTH DEPARTMENT		67 8653	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
MARTHA M. HERRIN			September 8, 1967 12:45 A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3701 Evergreen Avenue			A. STATE Maryland		
			B. COUNTY 27-34		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3701 Evergreen Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH XX May 18, 1918	9. AGE (In years last birthday) 49	10. If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wicomico Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Reed		14. MOTHER'S MAIDEN NAME Nora Elizabeth KXX Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-7122		17. INFORMANT ADDRESS Mr. Daniel W. Herrin 3701m Evergreen Ave.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease (A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 8, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9/11/67		23C. NAME of CEMETERY or CREMATORY Moreland Memorial Park	
				23D. LOCATION (City, town, or county) (State) Balto., Md. (Parkville)	
24A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		24B. NAME OF REGISTRAR 19570000		24C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.	

WALLACE MORRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

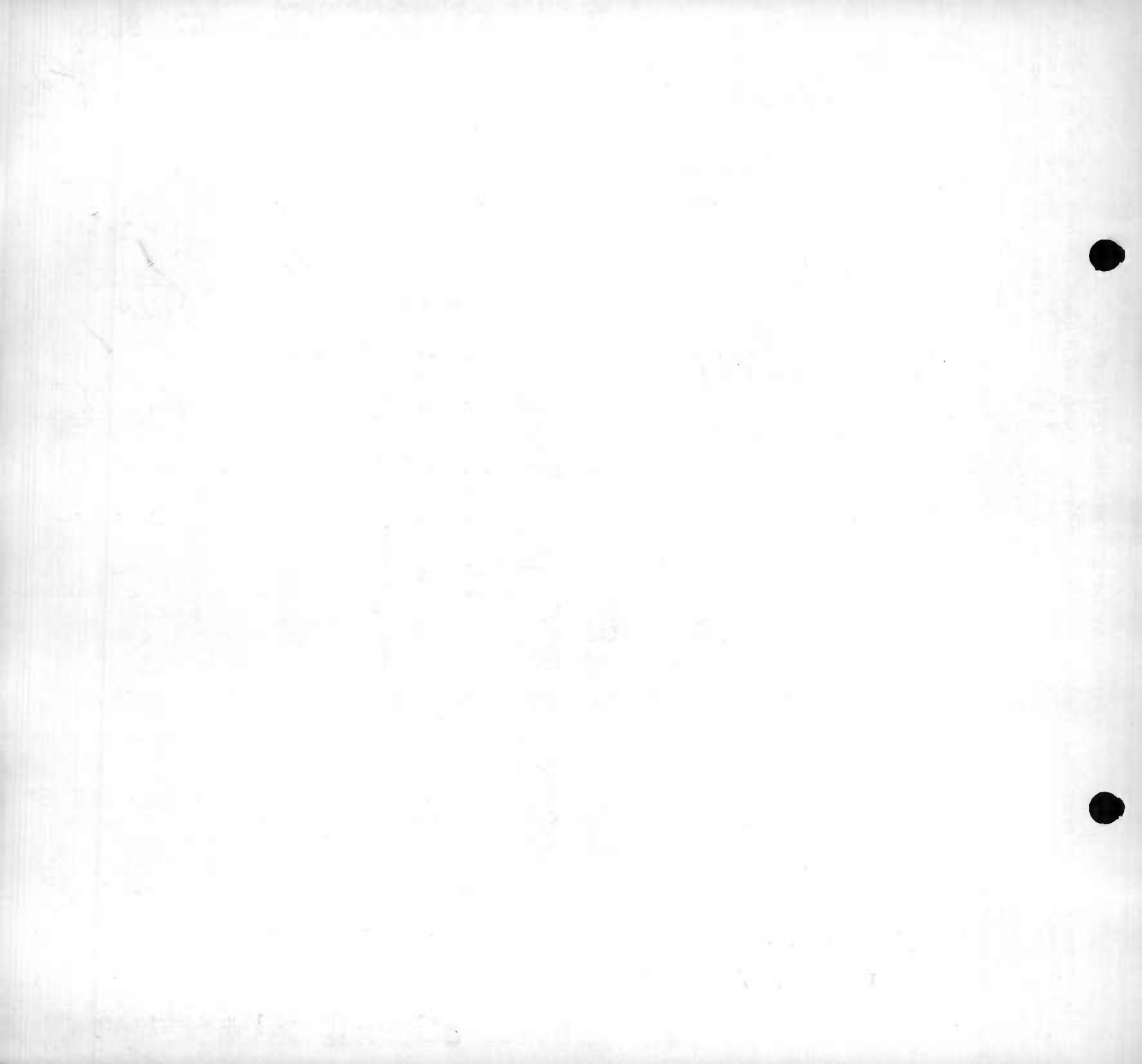
BIRTH NO. 67 8654				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8654	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Alexander Queen		September 6, 1967 6:30 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Provident Hospital Inc. 1514 Division Street Baltimore, Maryland 21217				Maryland			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male				Negro		Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Unemployed						9/2/68	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years lost birthday)	
Maryland				U.S.A.		78	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes				220-05-3120-A		Mrs. Hazel Connor (dau) 1635 Benson Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2						Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from August 15, 19 67 to September 6, 19 67, that (I) (we) last saw the deceased alive on September 6, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
C. Laredo						9/7/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
C. Laredo				1514 Division St. Balto., Md. 21217			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/11/67		National Cemetery		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 11 1967		Adolphus Halstead		1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8655		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8655	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Duffy, Peter</i>			2. DATE AND HOUR OF DEATH <i>9/10/67</i> <i>6⁰⁰ A M.</i>		
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>George Washington Nursing Home</i> <i>607 Pennsylvania Ave.</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>25-32</i>		
			D. STREET ADDRESS (If rural, give location) <i>2821 Round Rd.</i>		
5. SEX <i>male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>11-10-89</i>	9. AGE (In years lost birthday) <i>77</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNKNOWN</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Alfred Duffy</i>			14. MOTHER'S MAIDEN NAME <i>JEAN Blossom</i>		
15. Was deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-18-8942</i>		17. INFORMANT <i>Daughter Dehard Moore</i> ADDRESS <i>2821 Round Rd. Cherry Hill</i>	
18. <i>450.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Gen. Art. Sch.</i> DUE TO (B) <i>Bruni Syndrome</i> DUE TO (C) <i>C H F.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unk</i> <i>35 yrs.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/31</i> 19 <i>67</i> to <i>Sept 10</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9/8/</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E E Holt</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>9/10/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>E E Holt</i>		23D. ADDRESS M.D. <i>3715 Liberty Height</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/13/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Calvary Cemetry</i>	
24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>		25B. NAME OF REGISTRAR <i>R. G. E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i> ADDRESS <i>1206 W North Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8656	
BIRTH NO. 67 8656		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CLAUDIA WIGGINS		2. DATE AND HOUR OF DEATH SEPT. 7, 1967 7:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL		A. STATE MARYLAND B. COUNTY 13-02			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2225 1/2 LINDEN AVE - 21217			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated		8. DATE OF BIRTH 4/25/21	9. AGE (In years last birthday) 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter Johnson		14. MOTHER'S MAIDEN NAME Delia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 229-38-6576		17. INFORMANT Mrs. Annia Robinson, same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 171X I		CAUSE OF DEATH (A) METASTATIC CARCINOMA DUE TO (B) CA OF CERVIX (STAGE III-AB) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs. 2 1/2 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 1, 1965 to SEPT 7, 1967 , that (I) (we) lost saw the deceased alive on SEPT 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Patrick F. Dougherty, Jr.				23B. DATE SIGNED SEPT. 7, 1967	
23C. PHYSICIAN'S NAME (Type) PATRICK F. DOUGHERTY, JR.				23D. ADDRESS University of Maryland Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md					
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Adolphus		25C. FUNERAL DIRECTOR Halstead 1206 W North Ave	

101

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J-520

67 8657

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8657

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) FRANK N. JONES		2. DATE AND HOUR PRONOUNCED DEAD September 3, 1967 1:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3301 Edgewood Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3301 Edgewood Road	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Fertilize Factory	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Pearl Mosley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-8555	17. INFORMANT Mr Arthur W Jones, 2505 Elgin Ave
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9/12/67	23C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery
24A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		24B. NAME OF REGISTRAR Adolphus Halstead	24C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave
23D. LOCATION (City, town, or county) (State) A A County Md		ADDRESS	

1 2 3 4 5 6 7 8 9 10

✓

WALLEY HORSE

L-342

67 8658 BALTIMORE CITY HEALTH DEPARTMENT 67 8658

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK

LITTLEJOHN

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1967 1:17 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

639 N. Fulton Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

2/8/

9. AGE (In years
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Roosevelt

14. MOTHER'S MAIDEN NAME

Martha LittleJohn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Martha Littlejohn, 3332 Childs Court

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Massive Bleeding

(A) DUE TO gunshot wound of chest involving the
lung, aorta and pulmonary artery.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Bar

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Twinpines Tavern - 400 Blk.
Back River Neck Road

21D. TIME
OF INJURY
(APPROX.)

9/5/67 12:39 A.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subj. shot in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/13/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County M.

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North A

N 86 A 4 5 1 0 0 0 8 6 7 0

2/1/6

WALLEY MAPLE

WALLEY 130116E

2006/04/01

1/1/6

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 8659

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN or

EON

BONCEICH

Boncewich or Bancevich

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1967

10:55 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3349 Bonsal Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3349 Bonsal Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 17 1888

9. AGE (in years
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Janitor

10B. KIND OF BUSINESS OR INDUSTRY

Holy Trinity Church

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?
1st Papers

13. FATHER'S NAME

Richard Boncewich

14. MOTHER'S MAIDEN NAME

Irene Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-14-0832

17. INFORMANT

ADDRESS

Vera Boncewich 349 Bonsal St Balto 24, Md

18.

151X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Carcinoma of stomach with peritoneal
metastasesINTERVAL BETWEEN
ONSET AND DEATH(A).....
DUE TO(B).....
DUE TO

(C).....

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept 11 67

23C. NAME of CEMETERY or CREMATORY

Holy Trinity Cemetery

23D. LOCATION

(City, town, or county)

Elkridge

Md

24A. DATE REC'D BY HEALTH DEPT.

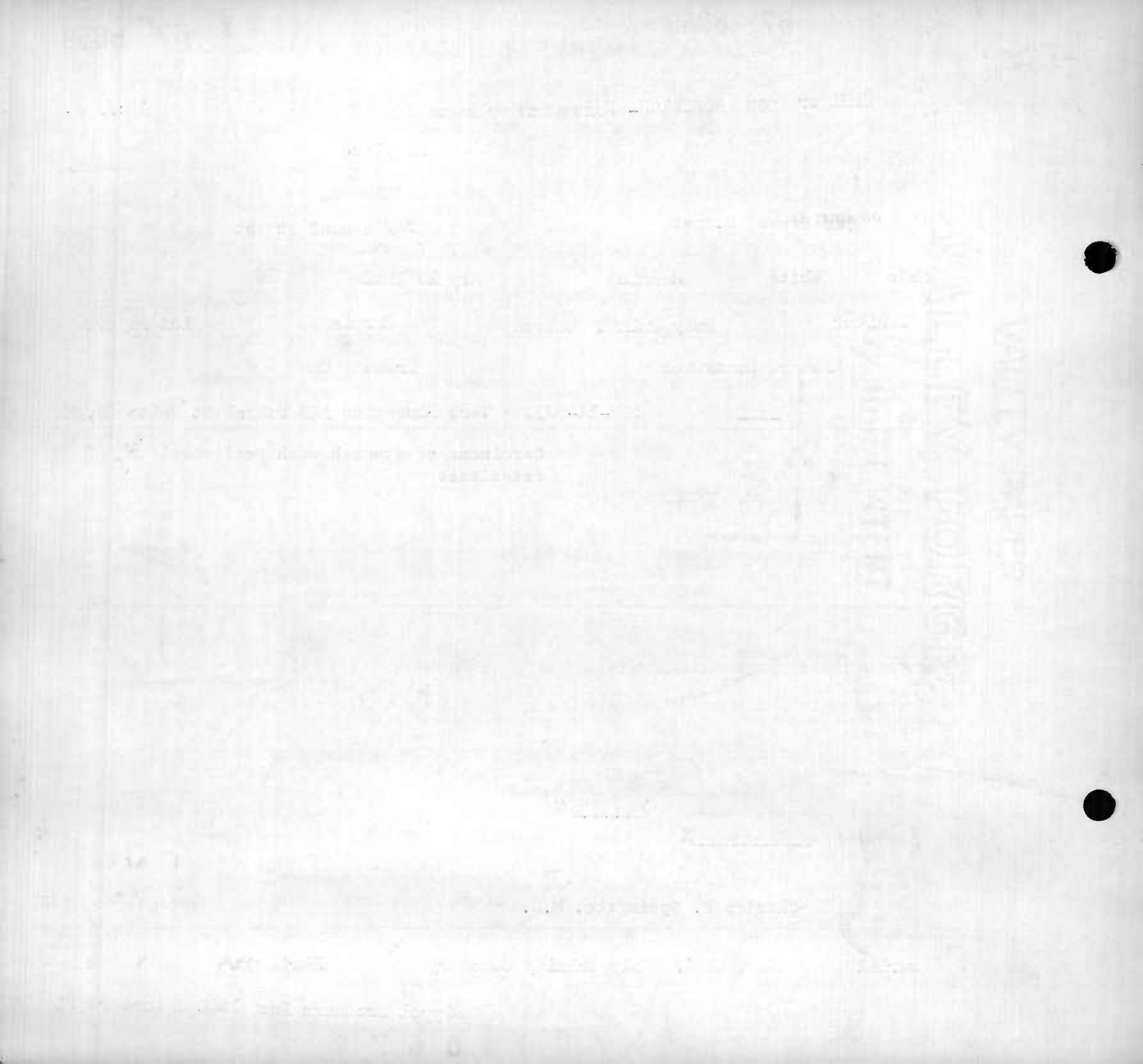
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 11 1967

Dippel Brothers Inc 1800 E Lombard St



1
J-525

67 8660

BALTIMORE CITY HEALTH DEPARTMENT

67 8660

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Helen E, (or)				2. DATE AND HOUR PRONOUNCED DEAD September 9, 1967 6:00 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) City Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. STREET ADDRESS (If rural, give location) CHAPEL 125 S. Chapel Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 10, 1909	9. AGE (In years last birthday) 58	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert Beasley				14. MOTHER'S MAIDEN NAME Ida Trott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Karl Jensen 125 S. Chapel St. 21231		
18. CAUSE OF DEATH E90051 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fracture of left leg							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 317 S. Baylis Street			
21D. TIME OF INJURY (APPROX.) 9 1 67 9:15 p.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subject fell down steps			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher NAME (Type) Russell S. Fisher, M.D. DATE SIGNED September 11, 1967							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Sept. 13, 67		23C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore. City. Maryland.	
24A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.		24C. FUNERAL DIRECTOR ADDRESS Dippel Bro, s Inc. 1800 E. Lombard St.			

1827106700000000

Replaced 9/13/67.-See Letter In File/
J.P.B.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILBUR GRIFFIN

2. DATE AND HOUR PRONOUNCED DEAD

September 9, 1967 8:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1500 N. Eden Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

never

8. DATE OF BIRTH

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John W. Griffin

14. MOTHER'S MAIDEN NAME

Sarah Boles

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Griffin Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....Multiple pulmonary emboli
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S

NAME (Type) Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

9-13-67 Burial

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

Mt Carmel Cmt

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 11 1967

VALLEY FARM
CAPITAL FUND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8662

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

TYRONE JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

September 9, 1967 7:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1222 E. North Ave.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

2-8-1946

9. AGE (In years
last birthday)

21

10. Under 1 Yr. 11 Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, when retired)

Salon

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Wilbur Johnson

14. MOTHER'S MAIDEN NAME

William Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

William Moore

ADDRESS

Scove

18. E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple gunshot wounds
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

lounge

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

L&M Lounge 1148 E. North Ave. 9-08

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 9 67 7:40 p.m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subject was shot during argument

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

September 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-14-67

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

R. S. Fisher

24C. FUNERAL DIRECTOR

Shay & Sons

ADDRESS

WILLIAM PRODUCE

1000/1000/1000

1000/1000/1000

1000/1000/1000

1000/1000/1000

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1000/1000/1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO.		67 8663	
M.E. CASE NO.		67 8663	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
ROBINSON WALTER JAMES		9/8/67 1:54 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
38 University Hwy		MD BALTO	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
		BALTO 15-01	
		D. STREET ADDRESS (If rural, give location)	
		722 Cumberland St #17	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
M	N		10/17/13
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday)
unemployed			53
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Bolto. Md		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JAMES		LORETTA PLATER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
unknown		unknown	J. STEER, MD 401 Maryland Hosp
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO	
ANTECEDENT CAUSES		Cardiac Arrest	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO	
		Myocardial Infarction	
		(C) Fibrinolysis, Hypotension	
		Subtotal Gastric Resection	
		Bilroth II	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Probable Carcinoma (Upper lobe lung)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
9/7/67			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO		NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED
J. STEER			9/8/67 JAM
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
J. STEER		401 Md Hosp Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	9-11-67	mt unknown	Balto Md
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
SEP 11 1967	John E. Steer	Joseph W. Steer / Wm Brumby Jr	

DATE 10/25/10
125 (number of 10/25)
10/25/10

H M M

10/25/10

10/25/10

Center Point

10/25/10

10/25/10

10/25/10

10/25/10

10/25/10

10/25/10

10/25/10

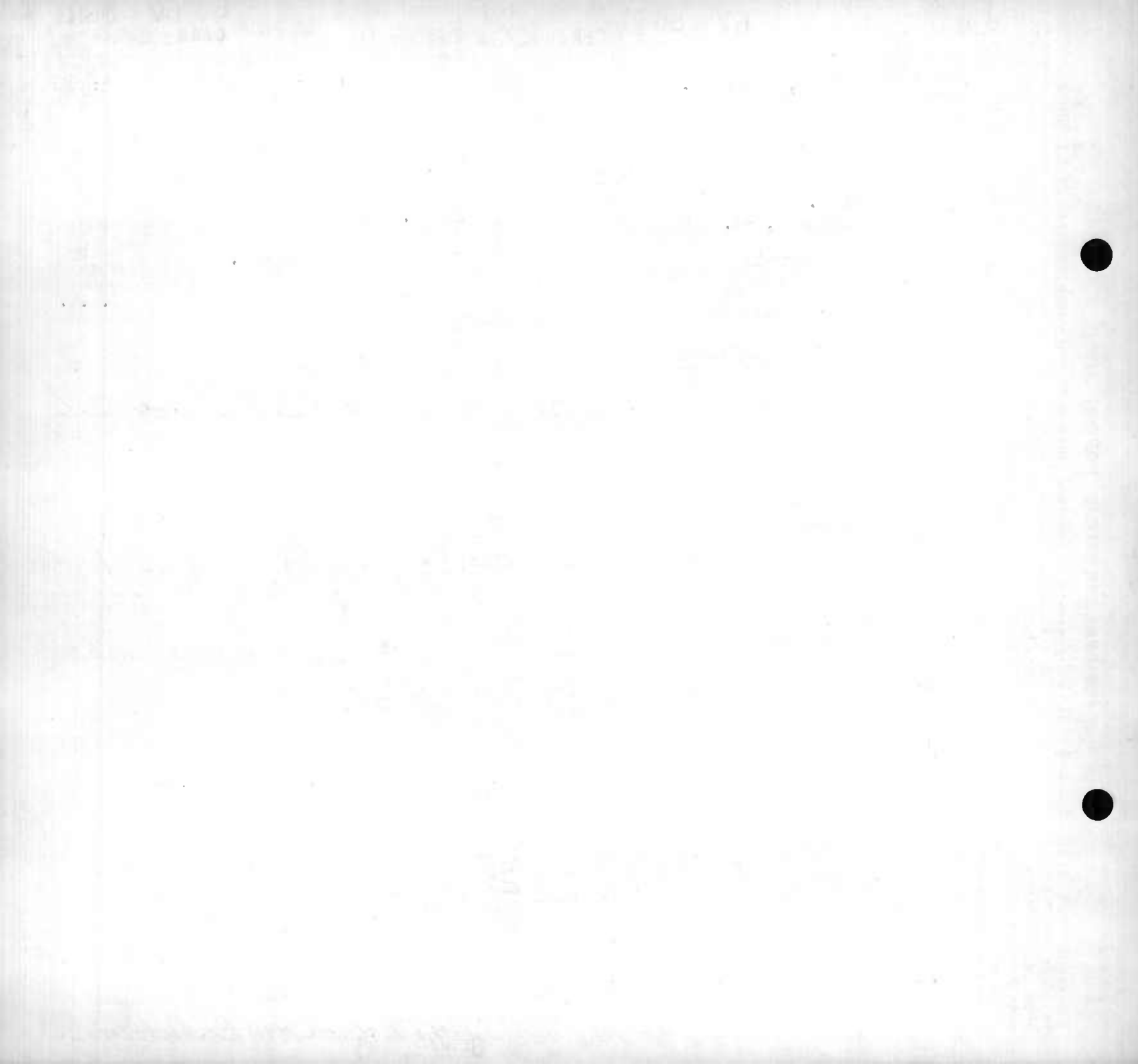
10/25/10

10/25/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

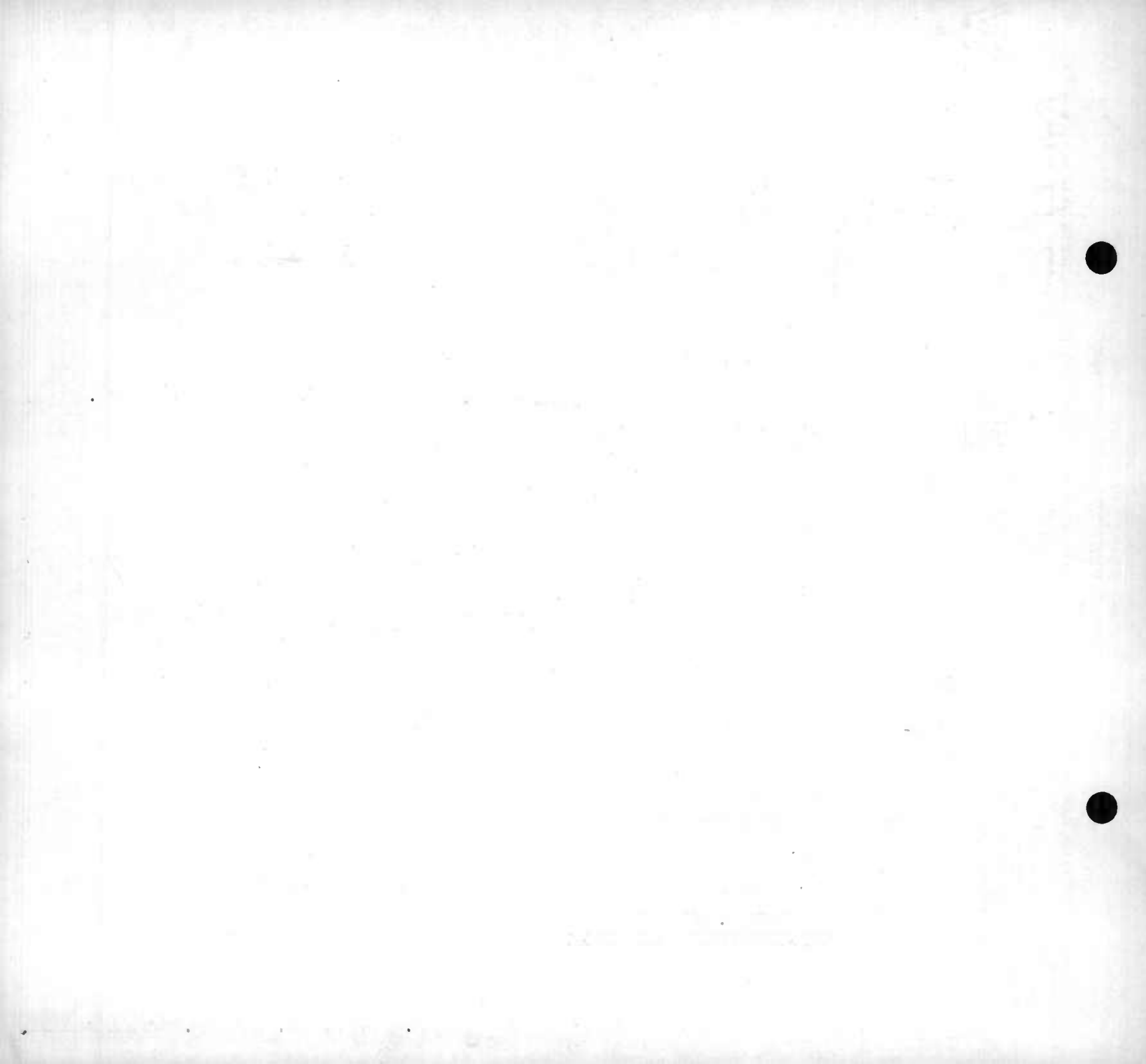
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. CANN, JAMES T.	
BIRTH NO. 67 8664		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CANN, JAMES T.		2. DATE AND HOUR OF DEATH (XXXXX) 9/08/67 4:45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital 601 N. Broadway Baltimore, Md. 21205		A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 293 S. Dallas Court			
5. SEX Male	6. RACE Negroid	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8/01/82	9. AGE (In years last birthday) 85 yrs.	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chestertown MD	
13. FATHER'S NAME ALEXANDER Cann		14. MOTHER'S MAIDEN NAME THOMAS, ANNIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217019738		17. INFORMANT Louma Cann	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypoxia		CAUSE OF DEATH (A) DUE TO Pulmonary Embolus (B) DUE TO Arteriosclerotic Heart Disease (C)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 6 hrs. 7 yrs.	
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 9/5/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/5 19 67 to 9/8 19 67 , that (I) (we) last saw the deceased alive on 9/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George H. Reed		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) George H. Reed		23D. ADDRESS Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) MD			
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR George H. Reed	
25D. ADDRESS		25E. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8665		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8665	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Bessie Kircher.</i>		2. DATE AND HOUR OF DEATH <i>9-7-67 6:10 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>24-02</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i>		D. STREET ADDRESS (If rural, give location) <i>1416 Woodall St.</i>		E. AGE (In years last birthday) <i>88</i>	
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow.</i>	8. DATE OF BIRTH <i>12-19-1888</i>	9. AGE (In years last birthday) <i>88</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Frederick Smith</i>	
14. MOTHER'S MAIDEN NAME <i>Barbara Hess</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. Ethel Heppding</i>		ADDRESS <i>1416 Woodall St.</i>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>BRONCHO PNEUMONIA</i>	
19. DATE OF OPERATION <i>8-31-67</i>		20. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fracture Left Hip</i>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	
22. I certify that (this hospital) attended the deceased from <i>8-29 1967</i> to <i>9-7 1967</i> , that (we) last saw the deceased alive on <i>9-7 1967</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <i>Qureshi</i>		24. DATE SIGNED <i>9-8-67</i>	
25. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>		26. NAME OF REGISTRAR <i>John A. Morgan, Inc.</i>		27. FUNERAL DIRECTOR <i>3000 E. Baltimore St.</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8666

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

NELSON

JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

September 3, 1967

6:25 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Florida

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Terrace

D. STREET ADDRESS (If rural, give location)

Terrace, Florida

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 7, 1942

9. AGE (In years
last birthday)

25 yrs.

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ellerton Florida

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Clifford Byrd

14. MOTHER'S MAIDEN NAME

Johnnie Mae Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

John Jackson

ADDRESS

18. E981X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Gunshot Wound of Groin
DUE TO(B) _____
DUE TO

(C) _____

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Mulberry and Pearl Sts.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9/3/67 6:00 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during labor dispute

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/3/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal Sept 8/67

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Bradenton Florida

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

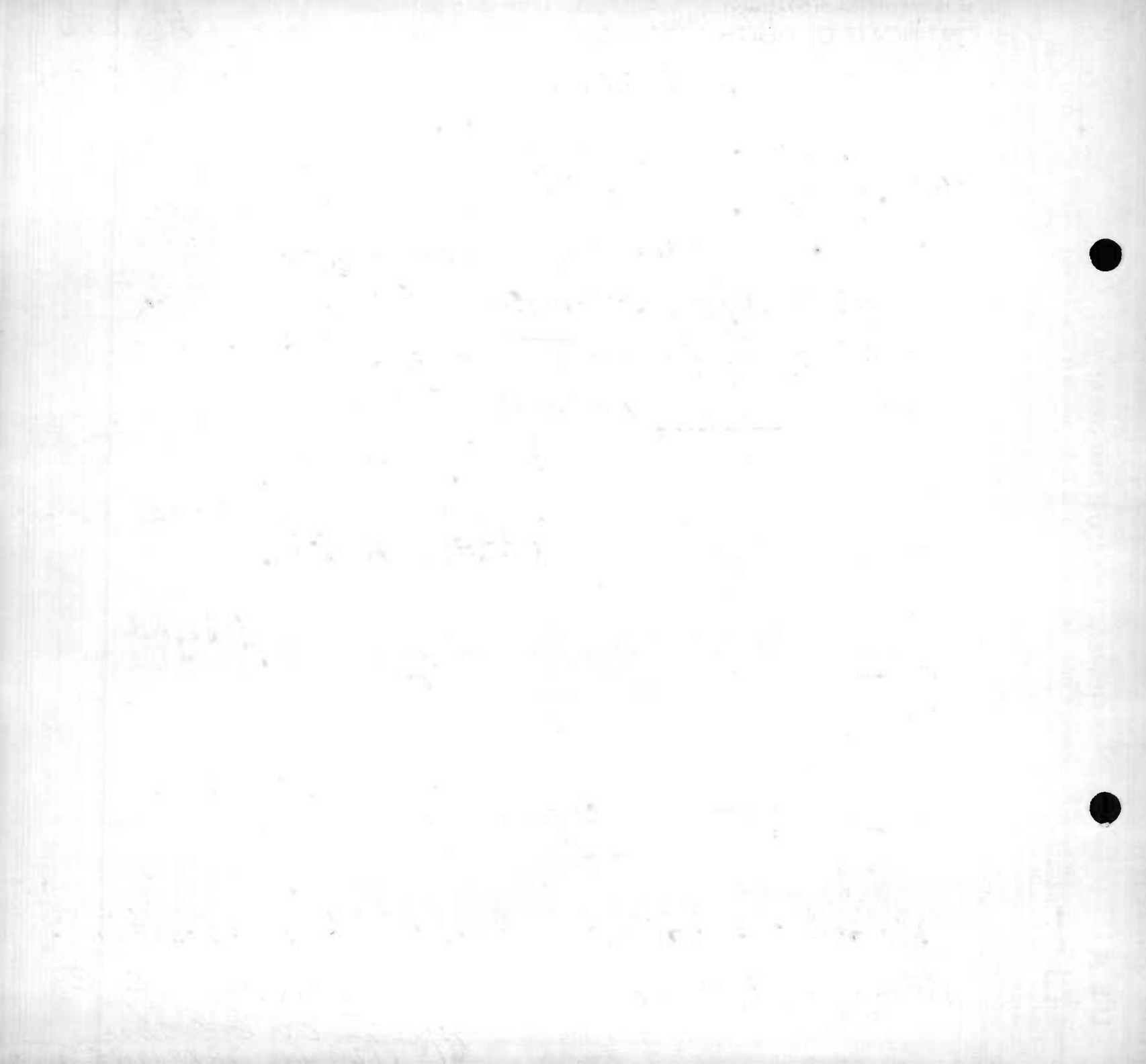
SEP 11 1967

Milton E. Erickson 1129 N. Curtis

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8667	
BIRTH NO. 67 8667		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) JOHN L. STEWART		Sept. 9, 1967 5:53 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hosp N. Charles & 28th Street		A. STATE Md. B. COUNTY Baltimore	
5. SEX Male		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
6. RACE N		D. STREET ADDRESS (If rural, give location) 2031 E. Lanvale St.	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 10-16-61	
9. AGE (In years last birthday) 61		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sweeping Machine Operator, Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? X	
13. FATHER'S NAME MITCHELL STEWART		14. MOTHER'S MAIDEN NAME Maggie Craine	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 21307-3649	
17. INFORMANT Chert		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 203X14260X		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Multiple Myeloma DUE TO (B) Hypertensive cardiovascular disease DUE TO (C) Diabetes Mellitus	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Interval Between Onset and Death	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-15 1967 to 9-9 1967, that (I) (we) last saw the deceased alive on Sept. 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE A. A. Silver attending		23B. DATE SIGNED Sept. 9, 1967	
23C. PHYSICIAN'S NAME (Type) AURORA T. HIPOLITO		23D. ADDRESS 6310 Park Heights Avenue NORTH CHARLES GENERAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal 9/13/67		24B. DATE 9/13/67	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Rock Hill, S. C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR		25D. ADDRESS Milton E. Blum	



1
B-656

67 8668 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8668

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALFRED

BERNARD

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1967 6:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)
913 Chauncy Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married Sep.

8. DATE OF BIRTH

April 21, 1907

9. AGE (In years last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Orleans La.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Alfred Bernard

14. MOTHER'S MAIDEN NAME

Lena Hennesy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

056-16-5689

17. INFORMANT

Irma Bernard 22W. 181st. St.

ADDRESS
Bronx N.Y.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/12/1967

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION (City, town, or county)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Williams Funeral Home 398 Schroeder St

10

[Handwritten signature]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8669

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD HAMILTON

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1967

10:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

933 W. Mulberry Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

933 W. Mulberry Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 1, 1898

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Fireman

10B. KIND OF BUSINESS OR INDUSTRY

Hospital

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Blanche Hamilton 933 W. Mulberry St.

18. 420.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic heart disease

(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 8, 1967

23A. BURIAL CREMATION,
REMOVAL (specify)

Burial

23B. DATE

Sept. 13, 1967

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

Ceder Hill Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Williams Funeral Home 3199 Schenck St.

WILLIE POINCE

NEW YORK

NEW YORK

0

NEW YORK

67 8670

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8670

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALFRED J. GOUGH

2. DATE AND HOUR PRONOUNCED DEAD

September 6, 1967 1:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1925 Ridgehill Ave.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12-13-18

9. AGE (In years
last birthday)

49

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Edward Marshall Gough

14. MOTHER'S MAIDEN NAME

Edna Adella Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW II

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mellicent Gough

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-11-67

23C. NAME OF CEMETERY or CREMATORY

Balto. Nat'l. Cem.

23D. LOCATION

Balto.

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

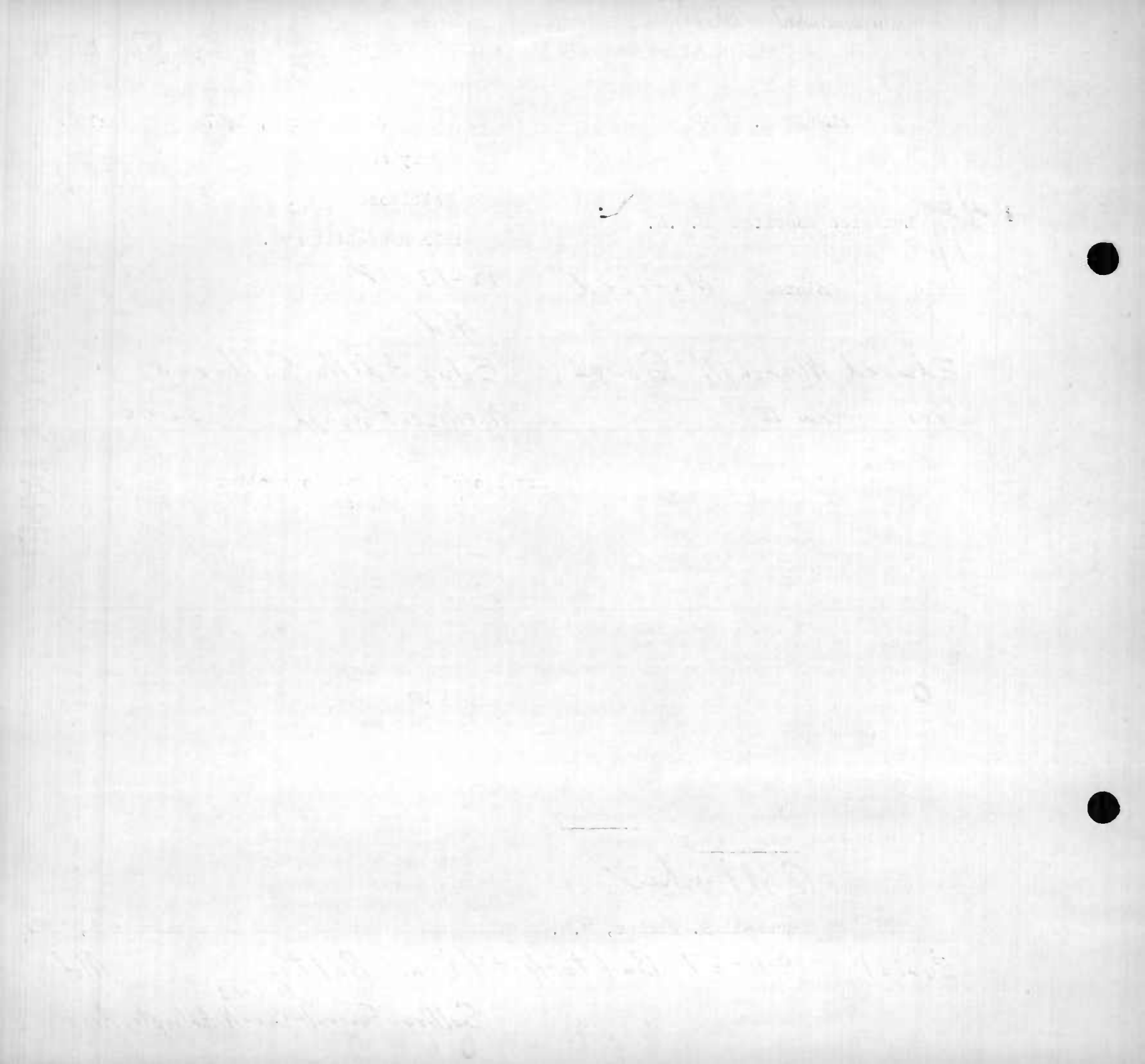
24B. NAME OF REGISTRAR

Russell S. Fisher

24C. FUNERAL DIRECTOR

Sullivan Funeral Home - N. Arlington Ave.

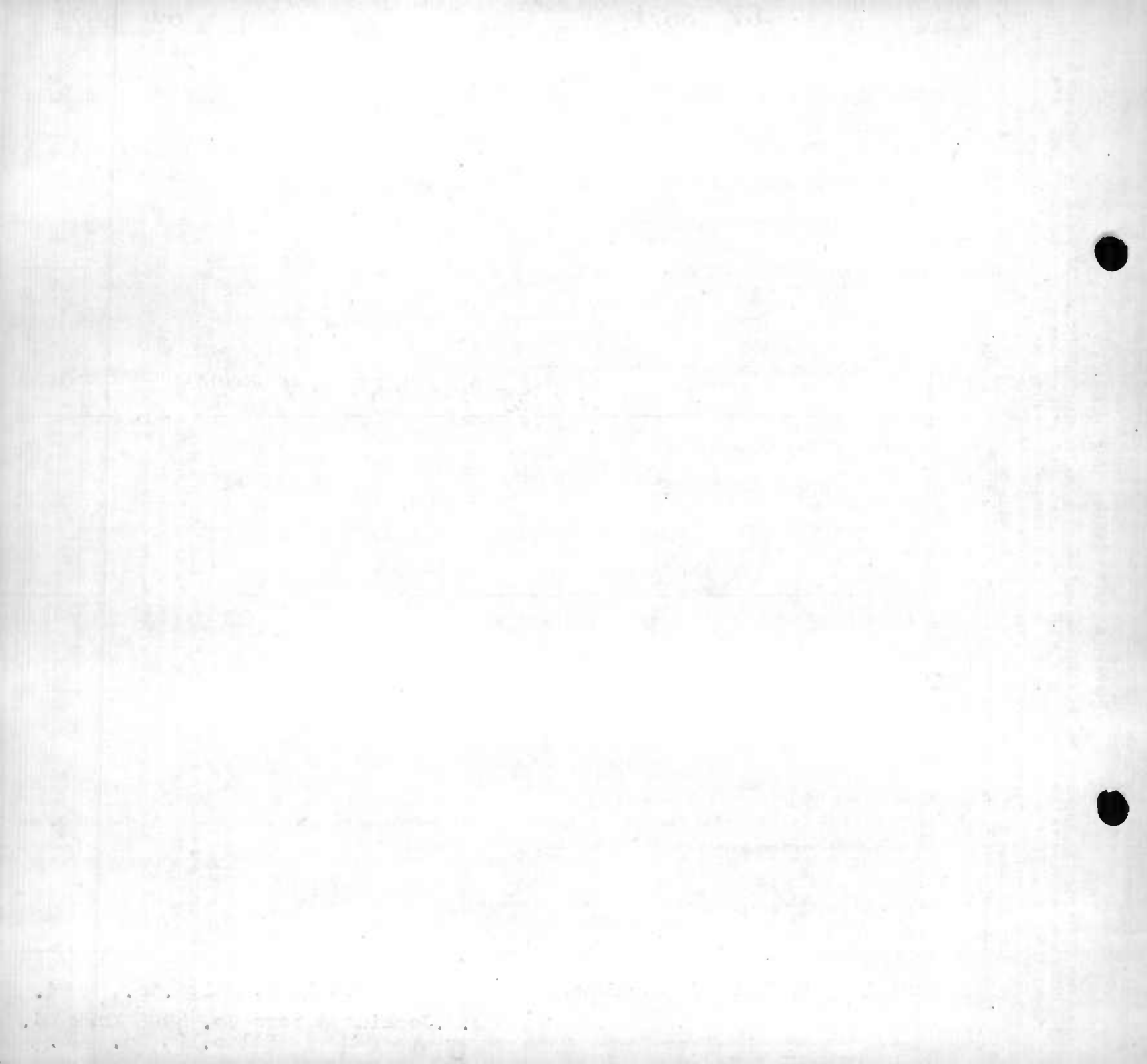
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8671		CERTIFICATE OF DEATH		67 8671	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ROMM, Mr. Raymond J.					
2. DATE AND HOUR OF DEATH 7/7/67 11:50 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md. General Hosp			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			27-09		
D. STREET ADDRESS (If rural, give location) 1512 Pentwood Rd					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-16-09	9. AGE (In years last birthday) 58	If Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY GREENHORN BUS		11. BIRTHPLACE (State or foreign country) BALTO, MD	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME LOUIS ROMM			14. MOTHER'S MAIDEN NAME CLARA BLOTKAMP		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 173-07-078		17. INFORMANT MRS. BETTY MAE ROMM (WIFE) ADDRESS (SAME)	
18. 163X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) CARCINOMA of Lung & METASTASES of Liver, Skin, CNS DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH about 1 yr
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---	
21D. TIME OF INJURY (APPROX.) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---	
22. I certify that (I) <u>this hospital</u> attended the deceased from 9-3 19 67 to 9-7 19 67 , that <u>he</u> last saw the deceased alive on 9-7 19 67 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>he</u> (did) (did not) view the body after death.					
23A. SIGNATURE Frank J. Zorick			23B. DATE SIGNED 7-7-67		
23C. PHYSICIAN'S NAME (Type) FRANK J. ZORICK			23D. ADDRESS 17d. General Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/1967		24C. NAME of CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR R. G. E. Talley		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

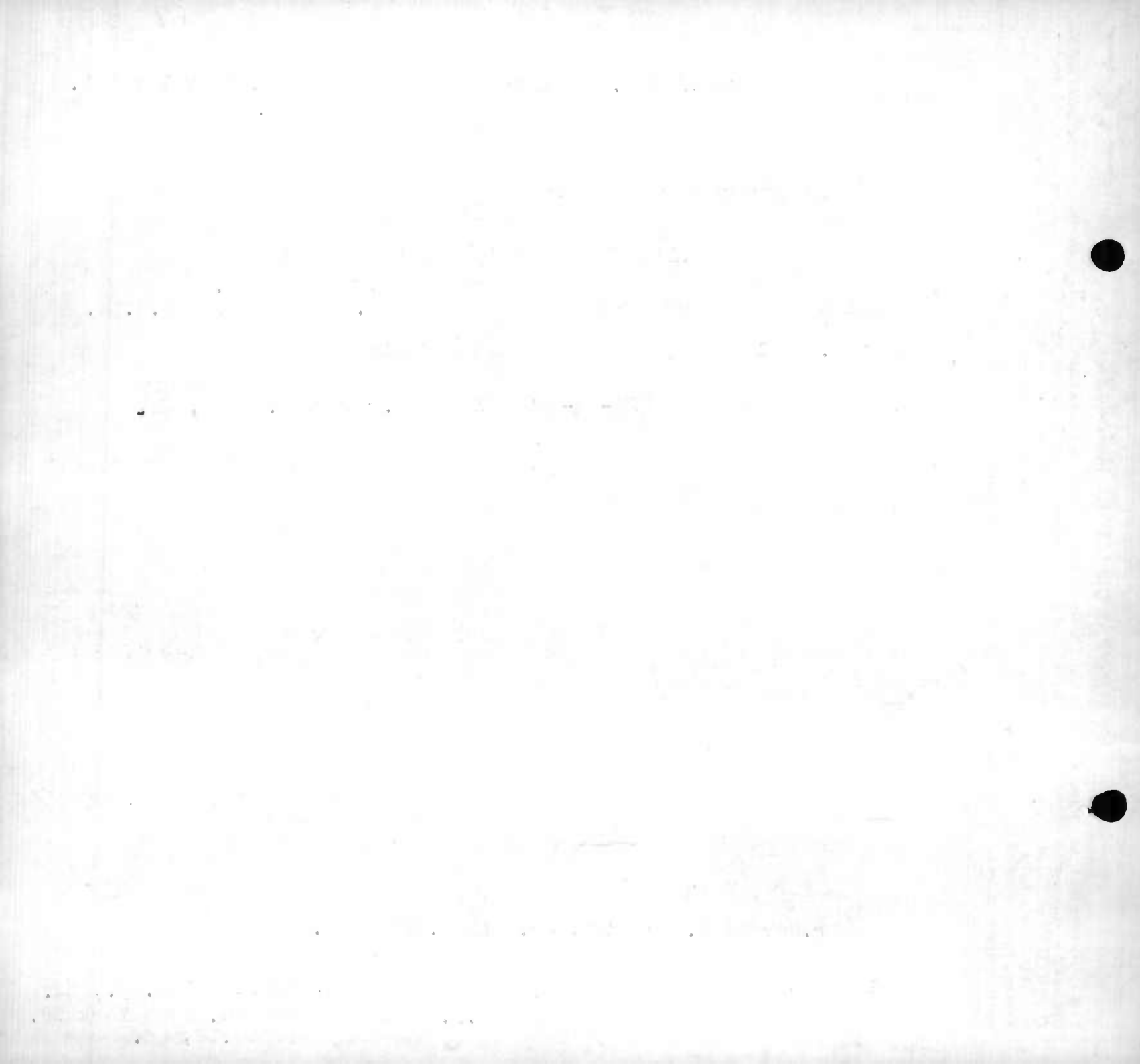
BIRTH NO.		67 8672		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8672	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
(Type or Print)		Louana Marion Sass		Sept. 8, 1967		7:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
US Public Health Service Hospital				Pa.			
3100 Wyman Park Drive				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Coraopolis			
D. STREET ADDRESS (If rural, give location)				8 Brook Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
F	W	Married	1/28/19	48			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Pa.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank Kopsa				Angelina Zabder			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		216-03-6042		Records- US PHS Hospital, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				Carcinoma right breast with cerebral metastases		9 mos.	
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Aug. 2 1967 to Sept. 8 1967, that (I) (we) last saw the deceased alive on Sept. 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Henry S. Crist, SA Surg (R)						9/8/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Henry S. Crist, SA Surg (R)		US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Rem. Burial		9/11/67		Coraopolis		Allegheny Co., Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
SEP 11 1967		H. W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

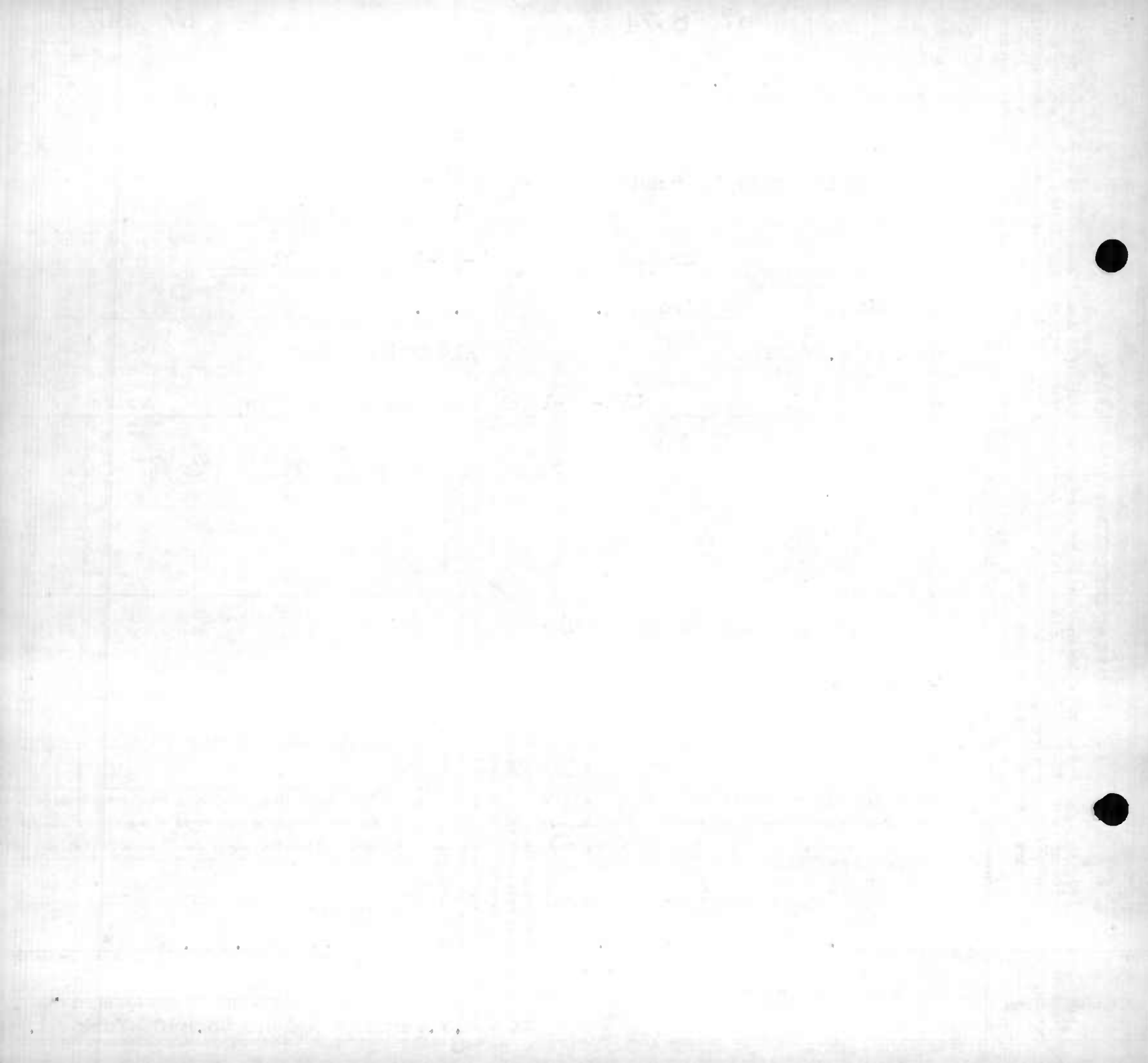
BIRTH NO. 67 8673				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8673	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Katharine D. Crummer				September 8, 1967 10:45 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 Longgreen Nursing Home				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				302 Suffolk Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
F	W	Widowed	5/4/1882	85			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Brookland, Potter Cty. Pa.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas G. Hull				Anna Marie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220-44-2488		Mr. George W. Baker, Jr.		302 Southway	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		3 da	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				A-S heart disease & edema		4-7 da	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
June 11, 1967		Ex lap		no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from March 15, 1960 to September 8, 1967, that (I) (we) last saw the deceased alive on 9/6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Norman R. Freeman, Jr.						9/8/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Norman R. Freeman, Jr.				11 W. 29th St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/11/1967		Druid Ridge		Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
SEP 11 1967		H.W. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8674				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8674	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				GEORGE E. CAFFEE JR.		9/8/67 5 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 212 Edgevale Road				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				212 Edgevale Road			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
M		W		Married		4-18-1896	
						9. AGE (In years last birthday)	
						71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Executive				Tire Mfg.		N. C.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George E. Caffee				Albertina Staub			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes				WW 1		216-05-1800	
						Mary Spence Caffee	
						Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Cerebro-vascular disease		2 1/2 years	
				(B) DUE TO			
				(C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				none			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0 None				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from August 1960 to September 8 1967, that (I) (we) last saw the deceased alive on September 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
L. Myrton Gaines Jr.				9/9/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
L. Myrton Gaines Jr.				7800 York Rd., Balto., Md.		21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-11-67		Druid Ridge		Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 11 1967		H. W. Jenkins		H. W. Jenkins & Sons Co.		4905 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8675		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8675	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mr. Robert W. Rennie</i>		2. DATE AND HOUR OF DEATH <i>9-10-67 12³⁵ PM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		A. STATE B. COUNTY <i>7726 Greenview Terrace - Md.</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>7726 Greenview Terrace</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>09-29-87</i>	9. AGE (In years last birthday) <i>79 yrs</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad Conductor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>B & O RR</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Robert H. Rennie</i>		12. CITIZEN OF WHAT COUNTRY? <i>(America) U.S.A.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>A-638-110</i>		17. INFORMANT <i>MRS. MALCOLM RENNIE</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Ca of esophagus</i>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		20. CAUSE OF DEATH (A) DUE TO <i>Metastasis to lungs</i> (B) DUE TO <i>Partial collapse of lungs</i> (C) DUE TO <i>Hemorrhagic Compaction of lungs</i> <i>Pleural effusion</i>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. INTERVAL BETWEEN ONSET AND DEATH <i>Manual Jensen</i>			
19A. DATE OF OPERATION <i>9.5.67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca of esophagus</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>8-17-1967</i> to <i>9-10-1967</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>9-10-1967</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Felise J. Martin</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-10-67</i>	
23C. PHYSICIAN'S NAME <i>DR. FELIX J. MARTIN</i>		23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/12/67</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>			
25B. NAME OF REGISTRAR <i>Regina E. Foy</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i>			

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FUNERAL DIRECTOR: IMPORTANT

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THIS CASE RELEASED AS NOT A MEDICAL EXAMINER'S CASE BY DR. CONTOS AVLOS

BIRTH NO. 67 8676		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8676	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GERRIT VAN DER STAAY			2. DATE AND HOUR OF DEATH 9-10-67 6:50 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13-01		
D. STREET ADDRESS (If rural, give location) 2408 LINDEN AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-14-95	9. AGE (In years last birthday) 71	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Holland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAN VAN DER STAAY		14. MOTHER'S MAIDEN NAME CORNELIA VanWaarden	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-0119152		17. INFORMANT Mrs. Betty VanderStaay ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CAUSE OF DEATH metastatic bladder carcinoma 9 months carcinoma of bladder 16 months pathologic fracture 30 days.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 8-21-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pathologic fracture hys		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2408 Linden Ave	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8-16-67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-15-1967 to 9-10-1967, that (I) (we) last saw the deceased alive on 9-10-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James L. Phillips M.D.				23B. DATE SIGNED 9-10-67	
23C. PHYSICIAN'S NAME (Type) JAMES L. PHILLIPS				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/67		24C. NAME OF CEMETERY or CREMATORY Maple Hill Cemetery	
24D. LOCATION (City, town, or county) Wilkes Barre, Pa.		(State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

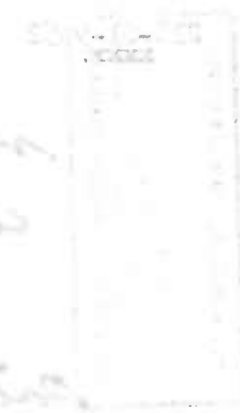
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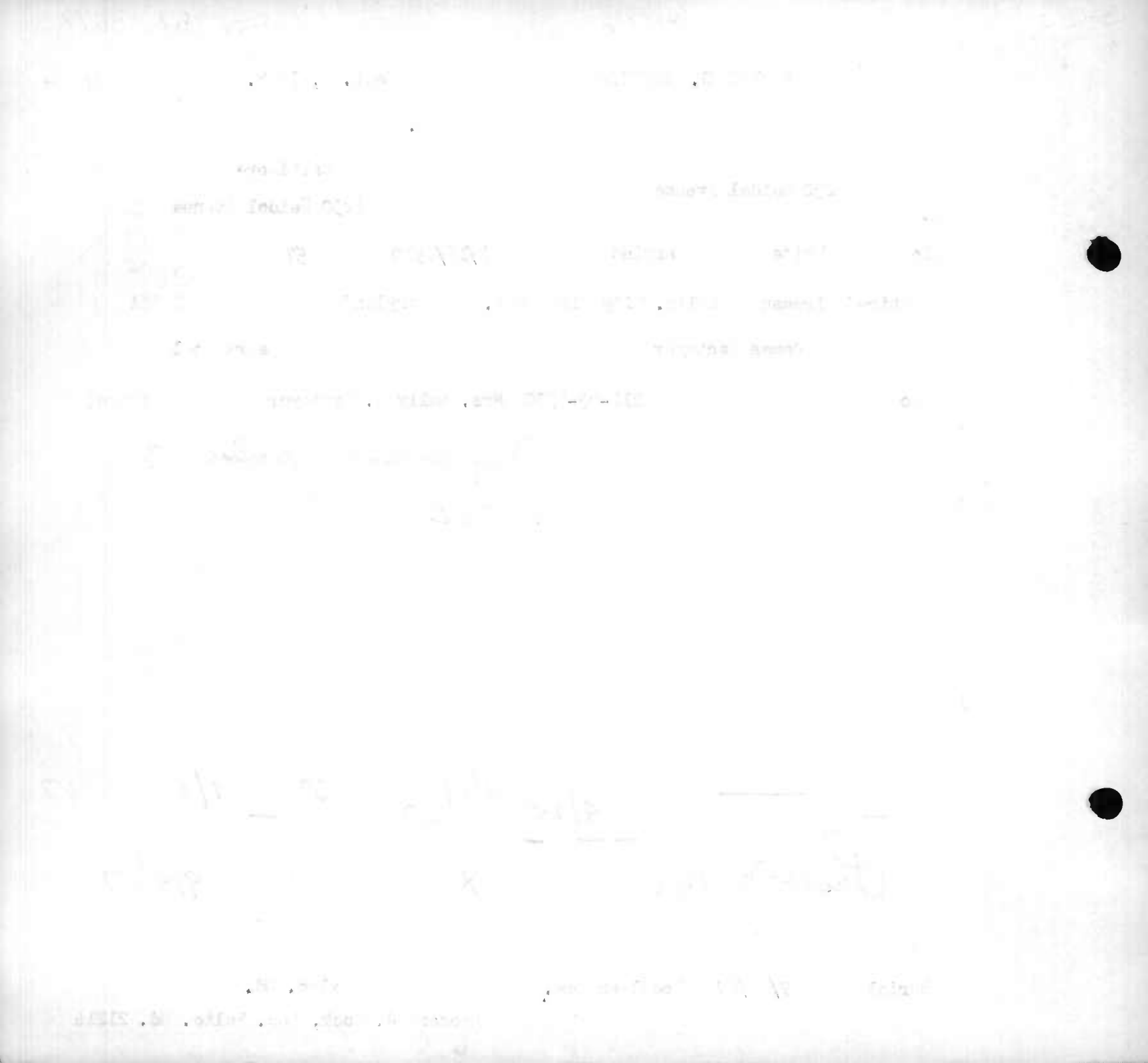
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8677</u>	
BIRTH NO. <u>67 8677</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROBERT G. SANTMYER		2. DATE AND HOUR OF DEATH Sept. 8, 1967. 11 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4230 Seidel Avenue		A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-02 D. STREET ADDRESS (If rural, give location) 4230 Seidel Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/16/1910	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman		10B. KIND OF BUSINESS OR INDUSTRY Balto. City Fire Dept.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Santmyer		14. MOTHER'S MAIDEN NAME Laura Pool	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-8930		17. INFORMANT Mrs. Emily M. Santmyer	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/19 19 67 to 9/8 19 67 , that (I) (we) last saw the deceased alive on 8/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE Paul S. Mueller				23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) PAUL G. MUELLER		23D. ADDRESS 6411 BELAIR ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. Md. 21214		25C. FUNERAL DIRECTOR ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8678	
BIRTH NO. 67 8678		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HARRY F. HARTWIG		2. DATE AND HOUR OF DEATH Sept. 8, 1967 1 8 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21206	
FULL NAME OF HOSPITAL OR INSTITUTION 4749 Shamrock Ave.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 4749 Shamrock Ave.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 15, 1888.	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown Terje Hartwig		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-01-0320		17. INFORMANT ADDRESS Mr. John C. Jensen, 9216 Nottingwood Rd. 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331X I Cerebral Vascular Accident		CAUSE OF DEATH (A) DUE TO Cerebral Vascular Accident (B) DUE TO Cerebral Arterio-sclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH months years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 19 62 to Sept 19 67 , that (I) (we) last saw the deceased alive on August 8, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis T. Daly				23B. DATE SIGNED 9-8-67	
23C. PHYSICIAN'S NAME (Type) Francis T. Daly		23D. ADDRESS 3201 North Charles Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967			
25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd.			

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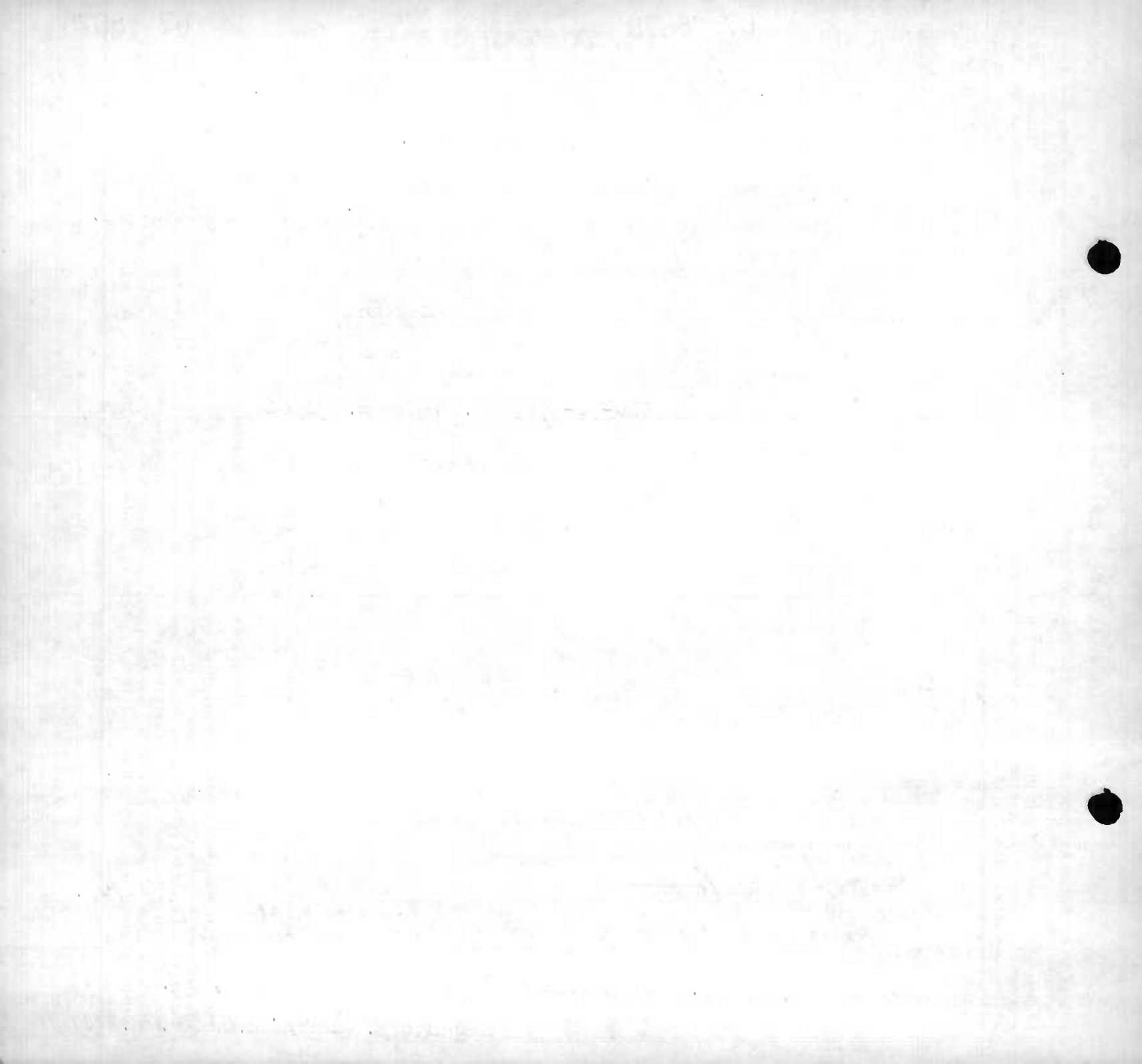
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8679	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARY D. ECKELS		2. DATE AND HOUR OF DEATH SEPTEMBER 10, 1967 2:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3216 Chesterfield Ave.			
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 12-6-98	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Peter Campbell		14. MOTHER'S MAIDEN NAME Mary Flaherty			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-48-3964		17. INFORMANT Mr. Henry L. Eckels	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CEREBRAL CORTICAL ATROPHY DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH unknown	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 9 19 67 to SEPTEMBER 10 19 67. that (I) (we) last saw the deceased alive on SEPTEMBER 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sayan L. Manaco				23B. DATE SIGNED 9/10/67.	
23C. PHYSICIAN'S NAME (Type) SAYANI L. MANACO		23D. ADDRESS MERCY HOSPITAL, 301 ST. PAUL PLACE BALTIMORE, MARYLAND 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/67.		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. *RECEIVED AS NOT A MEDICAL EXAMINER'S CASE, PER MR. MASON OF M.E. OFFICE.*

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8680	
BIRTH NO. 67 8680		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED JOHN DEGRUCHY HINE		2. DATE AND HOUR OF DEATH 9/10/67 1 10¹⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 5926 SEFTON AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 11-7-91	9. AGE (in years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager (Ret)		10B. KIND OF BUSINESS OR INDUSTRY Hecht Co.		11. BIRTHPLACE (State or foreign country) Canary Jersey Island, Islands	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN B. HINE		14. MOTHER'S MAIDEN NAME JANE DEGRUCHY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 109527		17. INFORMANT ADDRESS Mrs. Marguerite Marie Hine- Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus		CAUSE OF DEATH (A) DUE TO Chronic obstructive lung disease		INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 9-6-67 to 9-10-67 and that (I) (<u>we</u>) last saw the deceased alive on 9-10-67 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.					
23A. SIGNATURE <i>H. Michael Meagher</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/10/67	
23C. PHYSICIAN'S NAME (Type) H. MICHAEL MEAGHER		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Leonard J. Ruck Inc. 5305 Harford Rd.	
25C. FUNERAL DIRECTOR ADDRESS					

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67 8681 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8681

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EVELYN T. SOMERS

2. DATE AND HOUR PRONOUNCED DEAD

September 10, 1967 12:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland Howard Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ellicott City 21042 63-00

D. STREET ADDRESS (If rural, give location)

2 Middle Court

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

August 8, 1926

9. AGE (In years last birthday)

40 41

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Nicholas Z. Trivelis

14. MOTHER'S MAIDEN NAME

Mary Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unk.

17. INFORMANT

Mr. John A. Somers

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Rt. 29 & Rt. 40

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

9 2 67 2:15 a.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject was passenger in auto-auto

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

collision

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

September 10, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/12/67

23C. NAME of CEMETERY or CREMATORY

Greek Orthodox Cemetery

23D. LOCATION

(City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 11 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

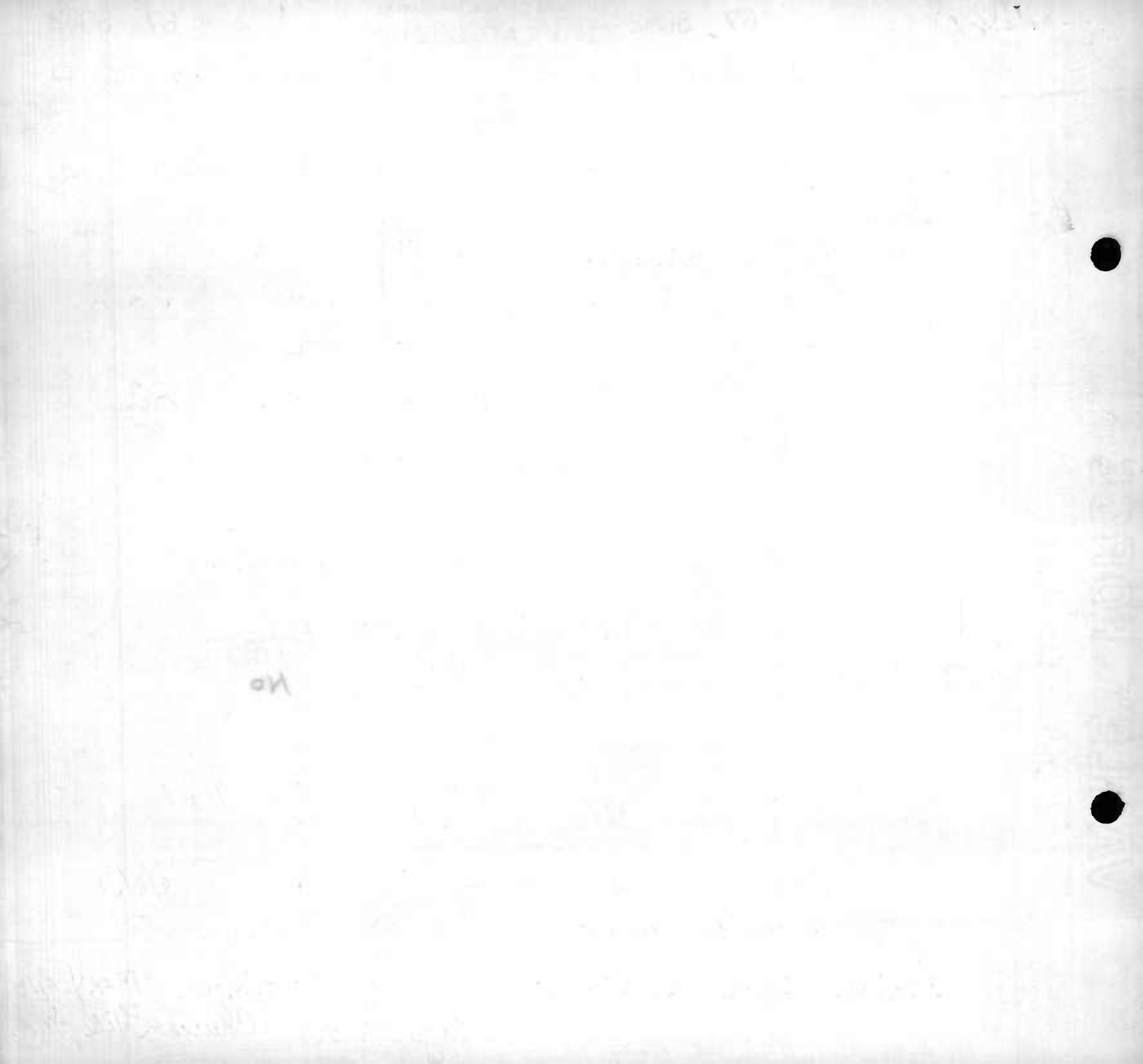
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VALLEY POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 67 8682	
BIRTH NO. 67 8682		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH September 6, 1967 2 P M.	
1. NAME OF DECEASED (Type or Print) Michael PELCZAR		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Queen Ann C.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital 33		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Chester, Md. (Rural) 67-00	
D. STREET ADDRESS (If rural, give location) —		5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWER	
8. DATE OF BIRTH 9/28/85 9. AGE (in years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) parts manufacturer	
11. BIRTHPLACE (State or foreign country) Krosno (POLAND)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK PELCZAR		14. MOTHER'S MAIDEN NAME ZAJDEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Eugene F. Pelczar		ADDRESS 15 S. Lynwood Ave Baltimore, Md	
18. 601X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) hydronephrosis DUE TO (B) urolithiasis DUE TO (C) Chronic urinary infection	
INTERVAL BETWEEN ONSET AND DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arterio sclerotic heart disease - Emphysema	
19A. DATE OF OPERATION 9/4/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Left ureteral calculus	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/3/1967 to 9/6/1967 , that (I) (we) last saw the deceased alive on 9/6/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ovidio Vitas M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/6/67	
23C. PHYSICIAN'S NAME (Type) Ovidio E. VITAS M.D.		23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE SEPT	
24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Edgar L. Lane - Church Hill, Md.	
25C. FUNERAL DIRECTOR		ADDRESS	



49-23-89GG

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8683		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8683	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Michael J. Kopeck		2. DATE AND HOUR OF DEATH 9/10/67 1 8²⁹ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS Baltimore City Hospitals 4940 EASTERN AVE., BALTO., MD. 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO., MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Frankford D. STREET ADDRESS (If rural, give location) 3615 FRANKFORT AVE. 21214			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 2-27-53	9. AGE (In years lost birthday) 14	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Charles Kopeck		14. MOTHER'S MAIDEN NAME Przybylowski, Wanda M			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMATION RECORDS: BCM 4940 EASTERN AVE., BALTO., MD 21224 Charles Kopeck - Same	
18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hodgkin's Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 9 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9/7 19 67 to 9/10 19 67 , that (2) (we) lost saw the deceased alive on 9/10 19 67 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) not view the body after death.					
23A. SIGNATURE S.W. Spaulding		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/10/67	
23C. PHYSICIAN'S NAME (Type) S.W. SPAULDING		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO., MD. 21224			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial 9/14/67		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd.	

all camp recent inspection

at

15/10

11/10
- 23/10

11/10/10
→
11/10/10
11/10/10

47-84-88
IV

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

47-84-88 IV		R-520 67 8684		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8684	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) RAINES, ELLA May				11 SEPTEMBER 1967 5:23 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE MARYLAND B. COUNTY BALTIMORE C			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 7908 Beverly Road - 21234			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 4/13/1922	
						9. AGE (In years lost birthday) 45	
						If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Milton Faults				14. MOTHER'S MAIDEN NAME ? Gentry			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-10-9075B		17. INFORMANT Records: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA - BILAT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 2ds							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CONGESTIVE HEART FAILURE							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 10/4 1966 to 9/11 1966 , that (I) (we) last saw the deceased alive on 10 SEPTEMBER 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Russell D Hicks				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11 SEPT. 1967	
23C. PHYSICIAN'S NAME (Type) RUSSELL D. HICKS				M.D. 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/67		24C. NAME OF CEMETERY OR CREMATORY Moreland Cemetery n		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS 5305 Harford Rd.	

Paterson - 21st

Concord - 1st

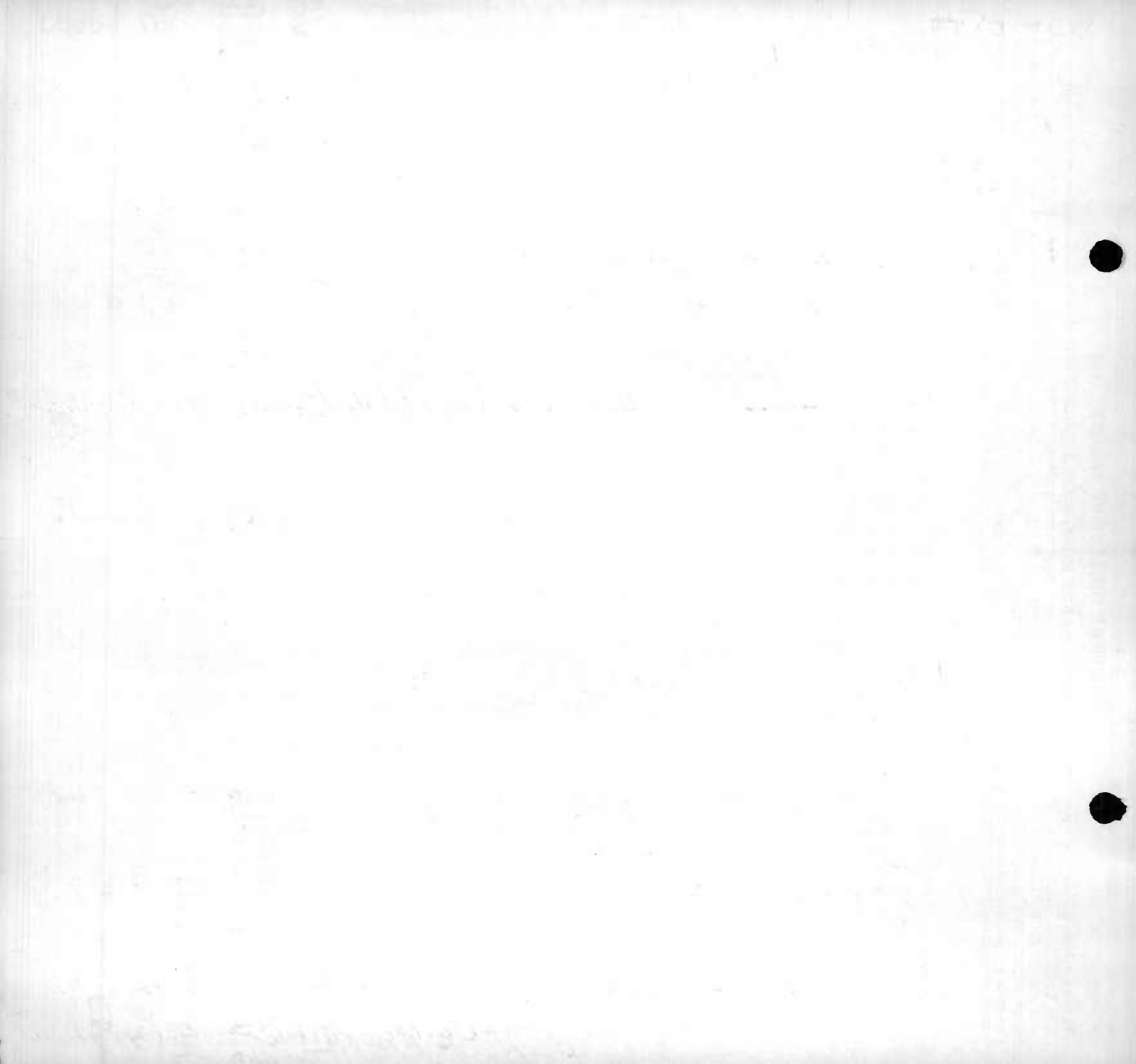
10 Dec 1867

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New York

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8685	
BIRTH NO. 67 8685		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Harry H Barnes</i>		2. DATE AND HOUR OF DEATH <i>9/8/67 (approx. 4 AM)</i> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		12-07	
		D. STREET ADDRESS (If rural, give location) <i>3124 Remington Ave.</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>1/27/84</i>	9. AGE (in years last birthday) <i>83</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brick layer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>construction</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George D. Barnes</i>		14. MOTHER'S MAIDEN NAME <i>Ruth A. Price</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215057056</i>		17. INFORMANT <i>Annie Idella Barnes</i>	
				ADDRESS <i>3124 Remington Ave</i>	
18. <i>422.1 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>ASCVD</i>			
ANTECEDENT CAUSES		(B) <i>acute gangrene of foot</i>		<i>6 weeks</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>8/30/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>acute gangrene of foot</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>8/15</i> 19 <i>67</i> to <i>9/8</i> 19 <i>67</i> , that (I) (<u>we</u>) last saw the deceased alive on <i>9/8</i> 19 <i>67</i> and that in (<u>my</u>) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.			
23A. SIGNATURE <i>Joseph S. Morin</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/8/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-12-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Pikesville Belto Co MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Berggren Funeral Home</i>		25D. ADDRESS <i>3631 Falls Rd</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8686	
BIRTH NO. 67 8686		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>George S Webb</i>		2. DATE AND HOUR OF DEATH <i>Sept 7 1967</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 House in the Pines (Belvedere)</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>3737 Elm Avenue</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Jul 28 1873</i>	9. AGE (In years lost birthday) <i>94</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Loom Fixer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cotton Mill</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Thomas Webb</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Reilly</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215 07 6356</i>		17. INFORMANT <i>Mrs Myrtle Hamer</i>	
18. <i>331 XI</i>		CAUSE OF DEATH		ADDRESS <i>3737 Elm Ave</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Cerebro Vasc Accident</i>		<i>1 day</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>Cerebro Vasc Insufficiency</i>		<i>2 years</i>	
		(C) <i>Generalized arteriosclerosis</i>		<i>20 years</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 10 1967</i> to <i>9/7 1967</i> that (I) (we) last saw the deceased alive on <i>9/6 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Leonard Wallenstein</i> M.D.				23B. DATE SIGNED <i>9/7/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Leonard Wallenstein</i> M.O.				23D. ADDRESS <i>848 W 36th St, Balto md</i>	
24A. BURIAL-CREATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-11-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Good Shepherd Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Howard Co. Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Burgess Funeral Home</i>			
25D. ADDRESS <i>3631 Falls Rd</i>					

KEY FOOT

Office in the [illegible] 373 Elm Street

John Smith, President July 24 1873

Virginia

Mr. Robert [illegible]

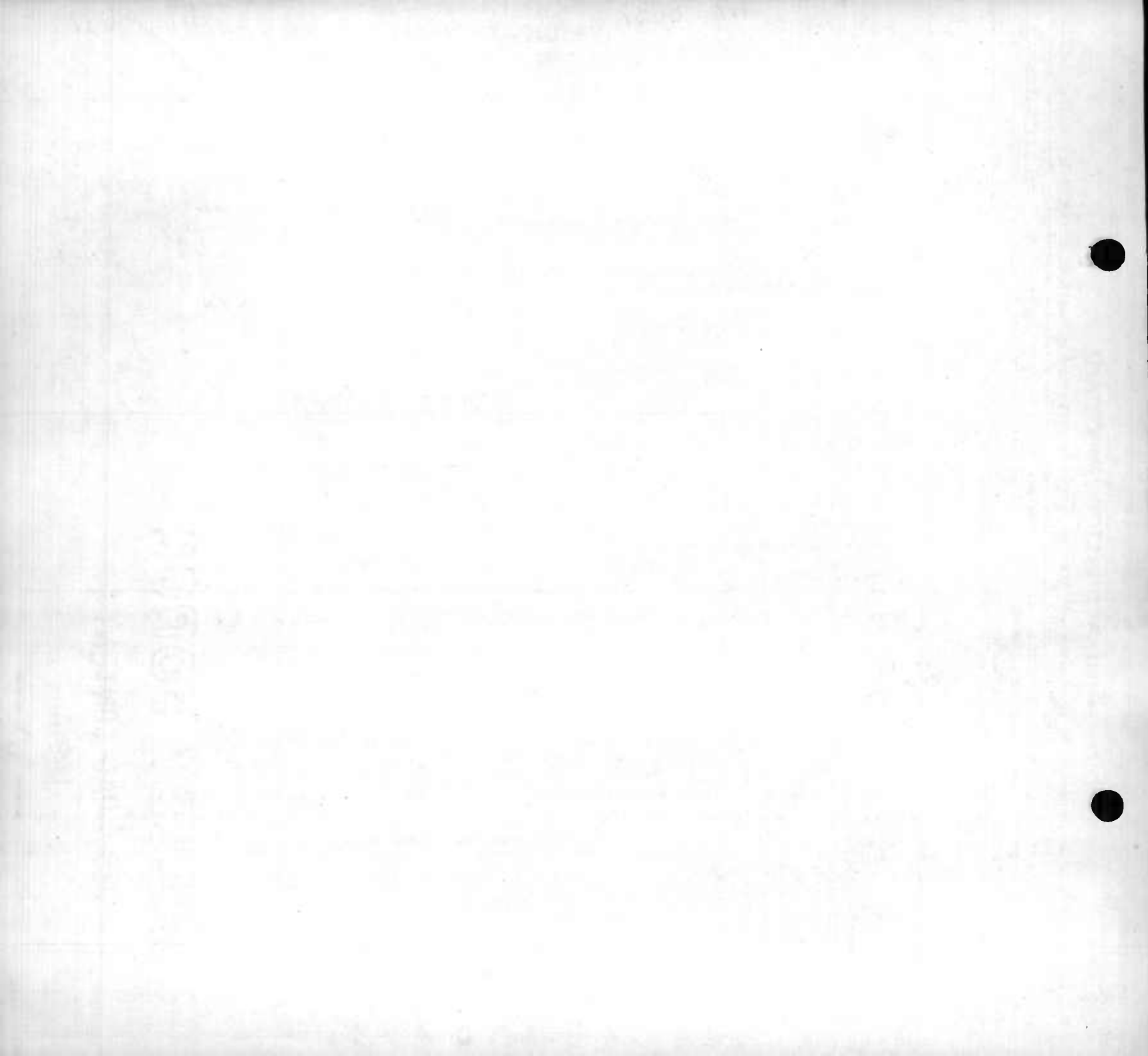
Thomas [illegible]

210 West [illegible] Street

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-17563		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8687	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY GIRL McCRAY			9-3-67 10:30 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL			A. STATE MARYLAND B. COUNTY		
If not in hospital or institution, give street address or location			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 1315 N. FRANKLIN ST.		
5. SEX F(?)	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 9-2-67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min. 14 44
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) FRANKLIN SQUARE HOSPITAL		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FRANK DAVIS			14. MOTHER'S MAIDEN NAME ELLA McCRAY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT RALPH McCRAY
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Immaturity			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 2 67 19 to Sept 3 67 19, that (I) (we) lost saw the deceased alive on 9-3-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Christina A. Feliciano			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-3-67
23C. PHYSICIAN'S NAME (Type) CHRISTINA A-FELICIANO			23D. ADDRESS FRANKLIN SQUARE HOSPITAL		
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY FR. Sq. Hospital	
				24D. LOCATION (City, town, or county) (State) BALTO. Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1967		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	
ADDRESS					



1
L-236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
FLORABELLE LEISTER		September 7, 1967 1:45 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland	
48 Maryland General Hospital		B. COUNTY Carroll Co	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Middleburg Taneytown 56-00	
		D. STREET ADDRESS (If rural, give location)	
		Brookfield Manor Nursing Home	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	White	Widowed	Apr. 16, 1889
		9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
		78	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Housewife		Maryland	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Own home		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Arnold		Lillie Slonaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		220-44-9861	
17. INFORMANT		ADDRESS	
Mrs. Emma Wildasin, Taneytown, Maryland			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Pneumonia complicating fractures of right femur and right humerus	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
8-18-67		fracture of femur	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		Nursing home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore, City, give exact location)		21D. HOW DID INJURY OCCUR?	
Brookfield Manor Nursing Home, Middleburg, Md.		Knocked off chair by another patient 56-00	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21D TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
8-16-67		A. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
Charles S. Springate, M.D.		September 8, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		Sept. 10, 1967	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Lutheran Cemetery		Taneytown, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
SEP 11 1967		Robert E. Taylor	
24C. FUNERAL DIRECTOR		ADDRESS	
C.O. Fuss & Son		Taneytown, Maryland	

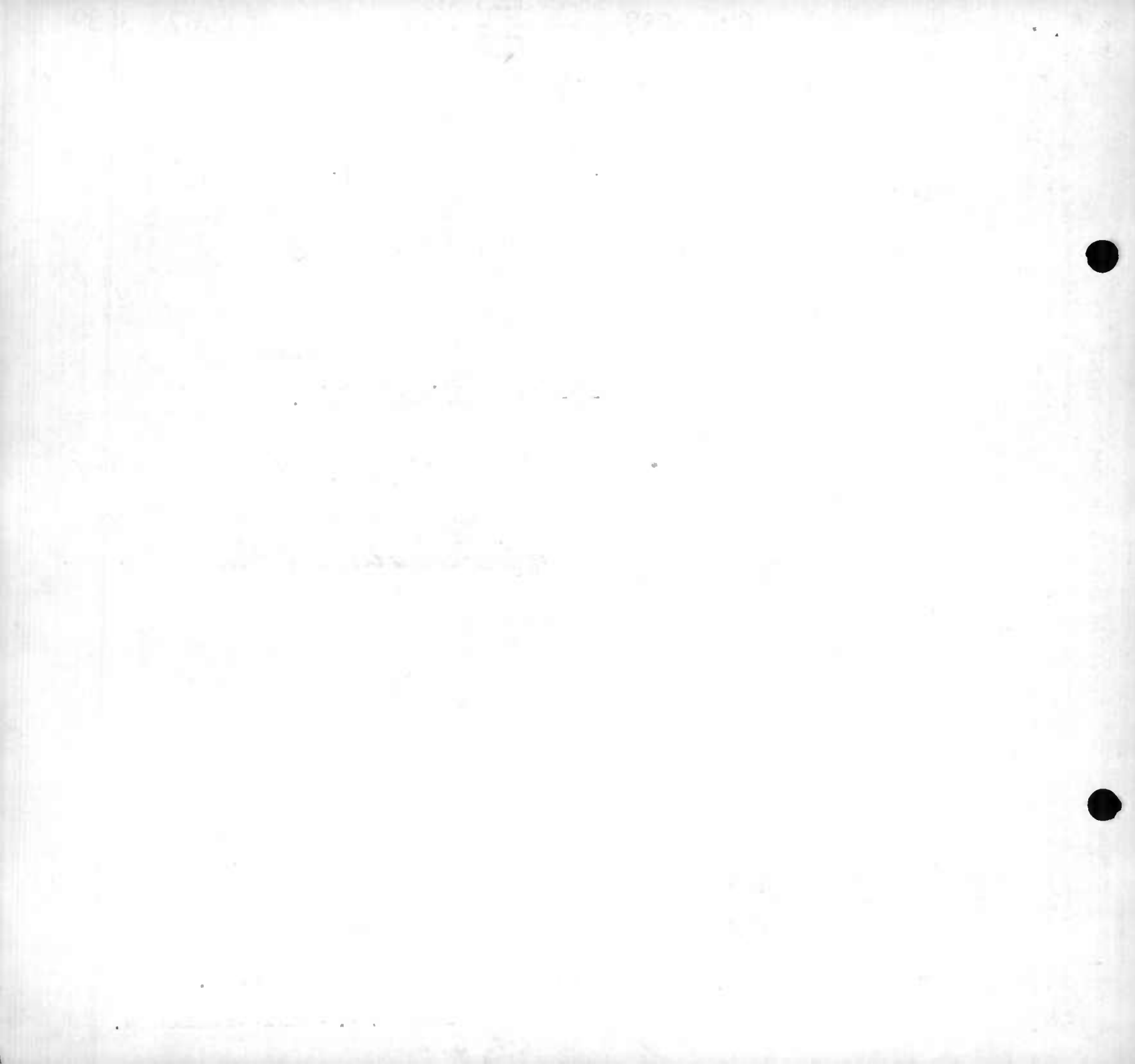
828.2 96700008700

RECEIVED
FEB 10 1964
FBI - NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

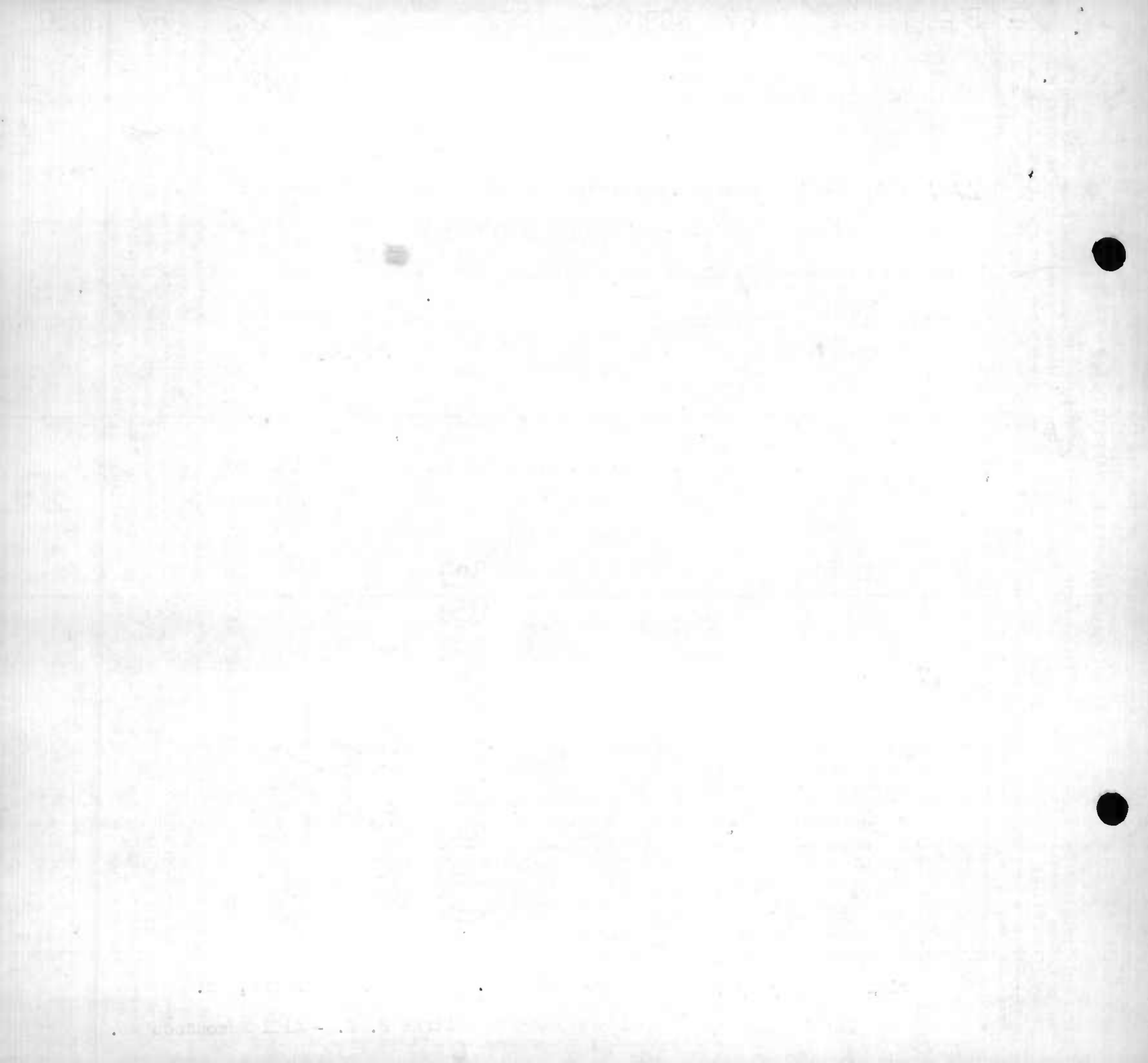
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Quinn Herbert Emerson				9-8-67 8:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hosp.				A. STATE Maryland.			
				B. COUNTY 28-04			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hosp.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229			
				D. STREET ADDRESS (If rural, give location) 4614 Manordene Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
m	w	married	6-17-04	63			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Registered				Texas		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
B.C. Quinn				Mary Schulman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				114-03-6027		Mrs. Anna Quinn 4614 Manordene Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		Myocardial infarction, recent + old	
				(B) DUE TO		Coronary arteriosclerosis	
				(C) DUE TO		Arteriosclerotic heart disease	
						1 day	
						10 years	
						10 years	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sep 8, 1967 to Sep 8, 1967, that (I) (we) last saw the deceased alive on Sep 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
C. BRAVO				9-8-67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
C. BRAVO				Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		9/12/67		Loudon Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
SEP 12 1967		R. G. & S. F. F. F.		Witzke F. D. - 4101 Edmondson Av.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

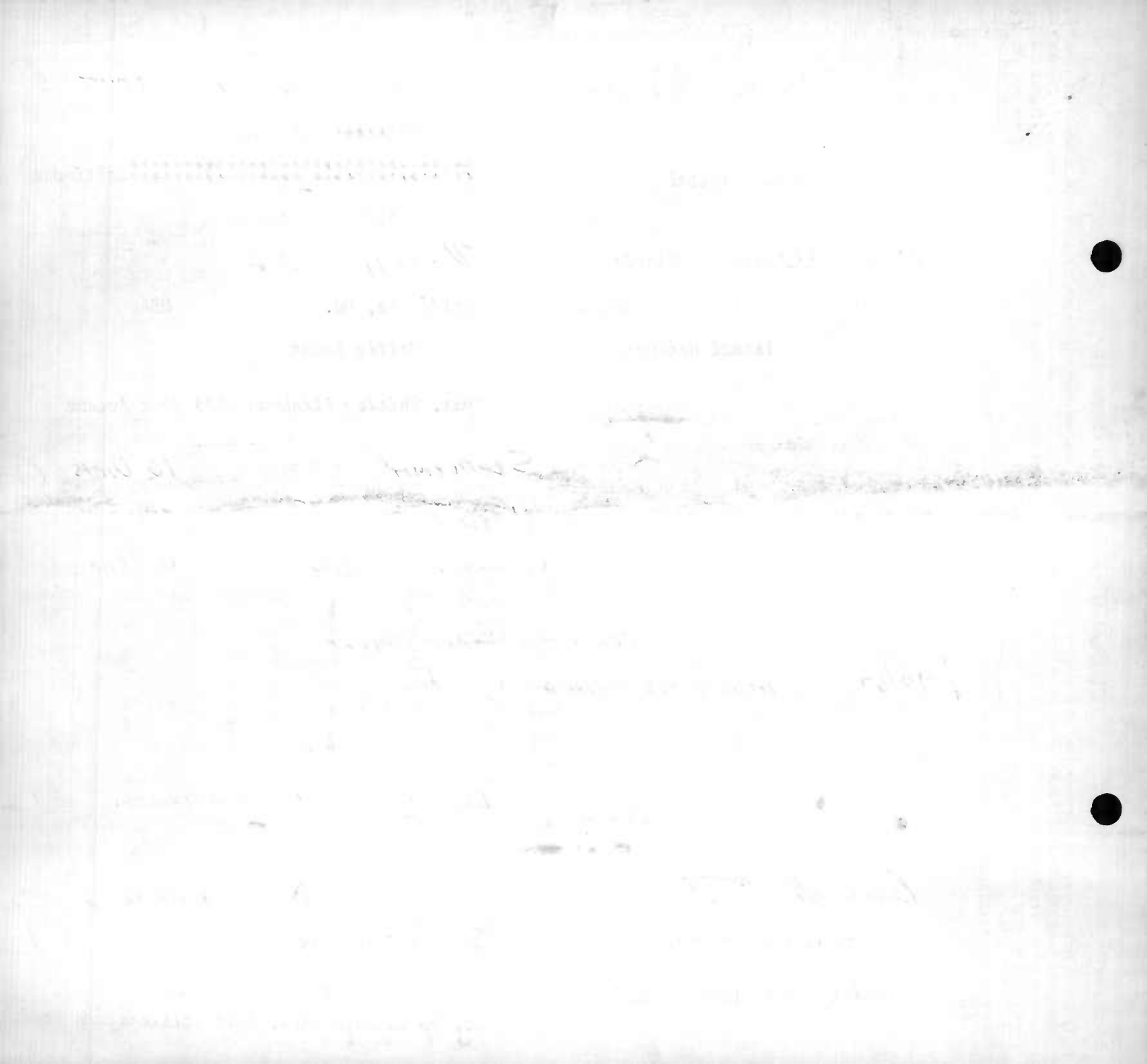
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 8690		CERTIFICATE OF DEATH		Registered No. 67 8690	
1. NAME OF DECEASED (Type or Print) CLARA ENGLES				2. DATE AND HOUR OF DEATH SEPT. 9, 1967 1 7⁰⁰ A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 MARYLAND GENERAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4449 NORFEN RD.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 11/16/95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE SIMS				14. MOTHER'S MAIDEN NAME JANE TAYLOR					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213 30 6572		17. INFORMANT DORIS BURTON		ADDRESS Same	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of Breast ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ↑ UREMIA				CAUSE OF DEATH (A) Metastatic Carcinoma of Breast DUE TO ↑ UREMIA (B) UREMIA DUE TO (C) —		INTERVAL BETWEEN ONSET AND DEATH 1 yr recent			
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION 0 NONE				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (If (this hospital) attended the deceased from SEPT. 7 19 67 to SEPT. 9 19 67 , that (I) (we) lost saw the deceased alive on SEPT. 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Frank J Zorick						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) FRANK J ZORICK						23D. ADDRESS MD. General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Witzke F. D. - 4101 Edmondson Av.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

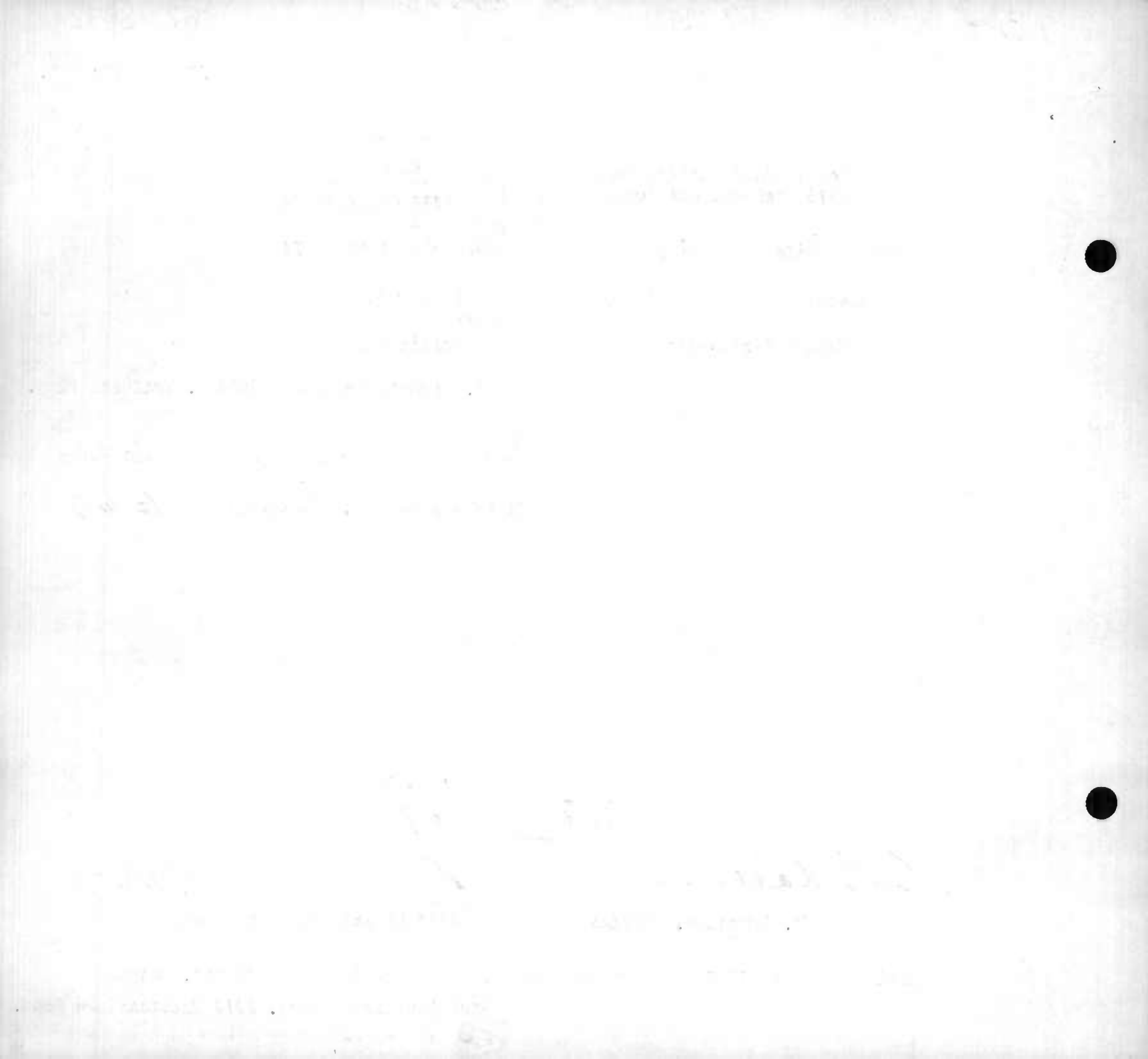
BALTIMORE CITY HEALTH DEPARTMENT									
67 8691 CERTIFICATE OF DEATH					Registered No. 67 8691				
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>SAMUEL HEILPERN</u>					2. DATE AND HOUR OF DEATH <u>8 SEPTEMBER 1967</u> <u>0245</u> <u>A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Maryland</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>5503 Nome Avenue</u>				
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>7/28/11</u>		9. AGE (In years last birthday) <u>56</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Israel Heilpern</u>					14. MOTHER'S MAIDEN NAME <u>Nettie Shear</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Shirley Flinkman 5503 Nome Avenue</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>SEPTICEMIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>UREMIA</u>					<u>2 MONTHS</u>				
<u>CARCINOMA OF COLON</u>					<u>4 YEARS</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CONGESTIVE HEART FAILURE</u>									
19A. DATE OF OPERATION <u>9/2/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hemodialysis - Uremia</u>			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>13 AUGUST 1967</u> to <u>8 SEPTEMBER 1967</u> , that (we) last saw the deceased alive on <u>8 SEPTEMBER 1967</u> and that in (my) (ap) in death occurred on the date <u>8 SEPTEMBER 1967</u> and hour and from the causes stated above. (I) (we) (ap) view the body after death.									
23A. SIGNATURE <u>Barry M. Potter</u>					23B. DATE SIGNED <u>8 SEPTEMBER 1967</u>				
23C. PHYSICIAN'S NAME (Type) <u>BARRY M. POTTER</u>					23D. ADDRESS <u>SINAI HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/10/1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Bnai Israel</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. 6010 Reisterstown Road</u>				



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 8692		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8692	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KATIE GOLD		SEPTEMBER 9, 1967		12:40 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE			
(If not in hospital or institution, give street address or location)		B. COUNTY			
90 Mount Sinai Nursing Home 4613 Park Heights Avenue		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		3736 Clarinth Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	White	Widow	November 1892	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		At Home		Lithuania	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Manuel Itzakowitz			USA		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
Bessie Stern					
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
			Mr. Isadore Goodman 3503 W. Northern Pkwy.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I		(A) Carcinomatosis		6 mo	
ANTECEDENT CAUSES		(B) Carcinoma of Colon		6 mo	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1963 to 1967 that (I) (we) last saw the deceased alive on 9/8 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. S. Kallins				9/9/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Edward S. Kallins				4300 Liberty Heights Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/10/1967		Progressive Sick Benefit & Relief	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 12 1967		Sol Levinson & Bros.		6010 Reisterstown Road.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8693

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GISELA WEISBERGER

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1967

4 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6801 Park Heights Avenue Apt. 1 C

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan. 4, 1893

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Book Shop

11. BIRTHPLACE (State or foreign country)

Austria

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Solomon Weisberger

14. MOTHER'S MAIDEN NAME

Charlotte Langer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Joseph Bernstein 1508 1st National Bank Building

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

Multiple traumatic injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, fam, lactory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Park Heights and Lebyrinth Road

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8-29-67

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 8, 1967

23A. BURIAL CREMATION
REMOVAL (Specify)

Burial

23B. DATE

9/9/1967

23C. NAME OF CEMETERY or CREMATORY

Louden Park Crematory

Balto. Hebrew Cemetery

23D. LOCATION

(City, town, or county)

(State)

2100 Belair Rd. Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1967

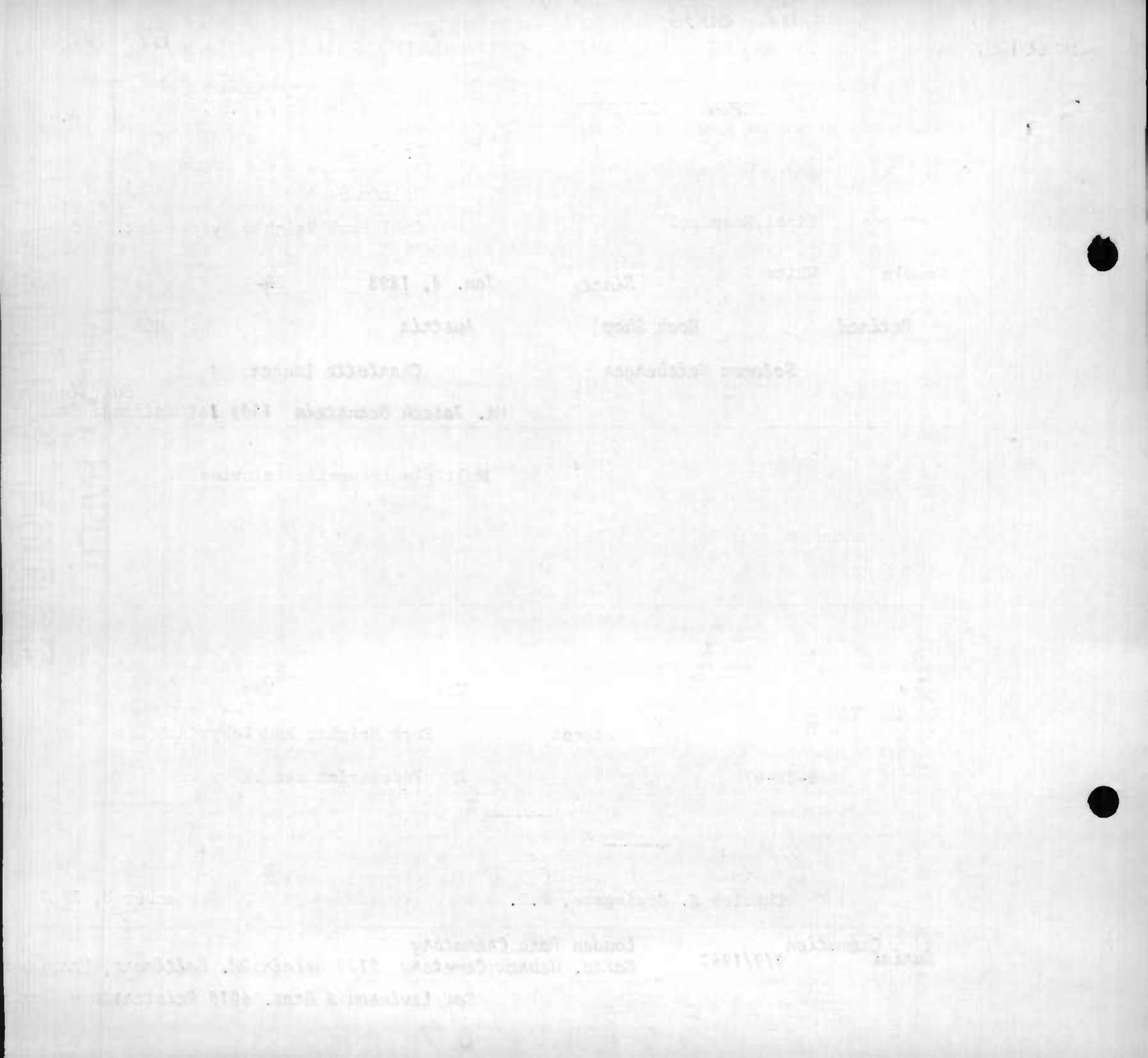
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

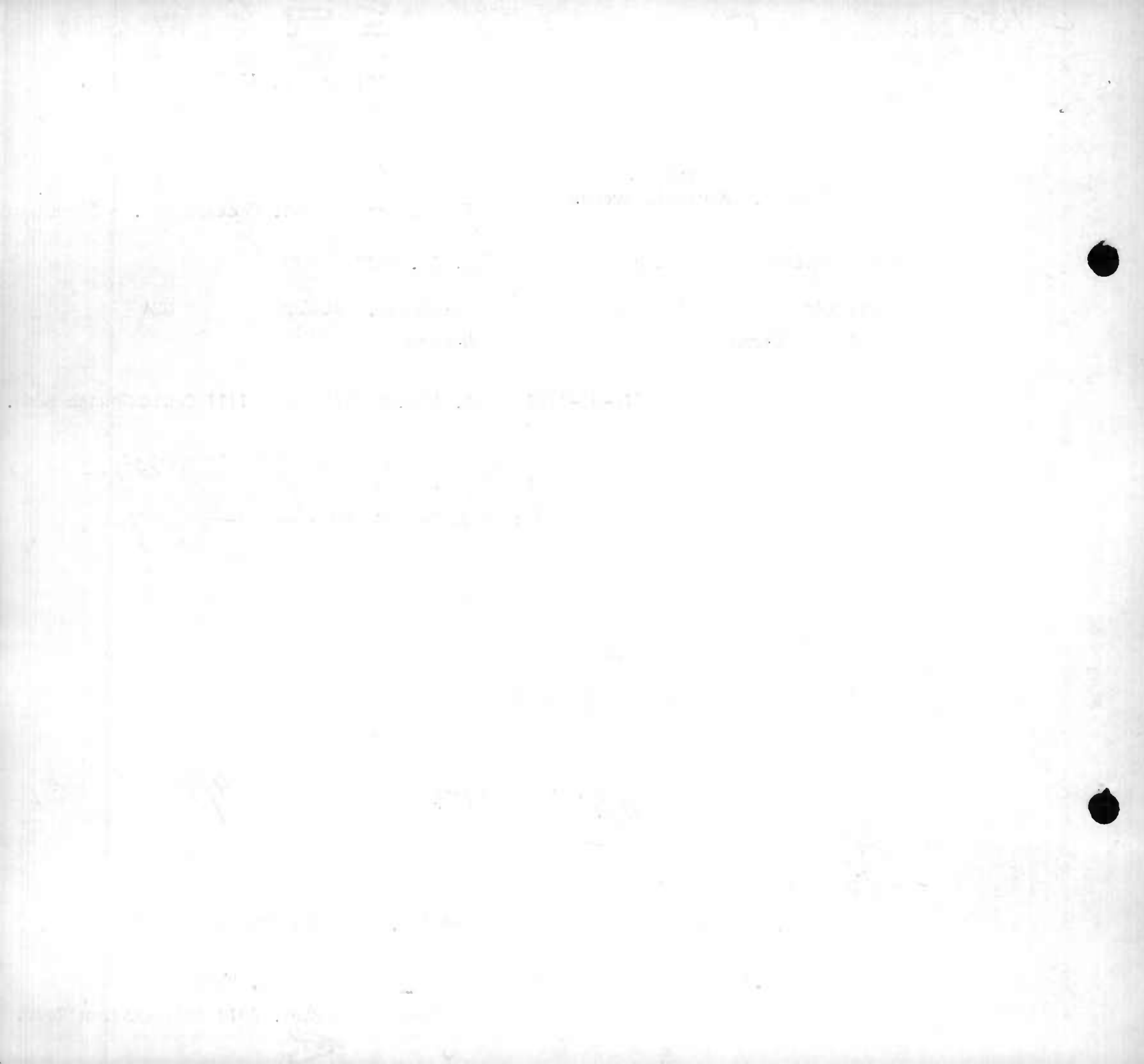
Sol Levinson & Bros. 6010 Reisterstown Road



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8694	
BIRTH NO. 67 8694		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THERESA LIEPMAN		2. DATE AND HOUR OF DEATH September 8, 1967 6 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Belvedere Nursing Home 2525 W. Belvedere Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 13-01 Rd. Temple Garden Apts. Madison Ave. & Cloverdale			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Jan. 23, 1878	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Brown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-32-2437D		17. INFORMANT ADDRESS Mr. Leonard Liepman 1111 Court Square Bldg.	
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinomatous 20 to 25 yrs (B) Heart malformation (C) Stroke due to Ht disease		INTERVAL BETWEEN ONSET AND DEATH 25 yrs yes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1948 to 9/8 19 67 , that (I) (we) last saw the deceased alive on 9/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Milton Kirsh				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Dr. Milton Kirsh		23D. ADDRESS M.D. 4000 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 10/67		24C. NAME of CEMETERY or CREMATORY Hebrew Friendship	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967			
25B. NAME OF REGISTRAR Sol E. Levinson		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Road.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance, on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8695	
67 8695				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Joseph CUTLER	
2. DATE AND HOUR OF DEATH 9-8-1967 1:30 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Levindale Aged Home			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY Baltimore		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
6. STREET ADDRESS (If rural, give location) Levindale + Hebr... 3217 Woodland Avenue		7. DATE OF BIRTH 2-11-1881			
8. AGE (In years last birthday) 86		9. SEX Male		10. RACE White	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		13. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 100-07-0775	
17. INFORMANT Son Milton Cutler		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bronchogenic Carcinoma		19. CAUSE OF DEATH 2 yrs.	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II			
22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-22-1967 to 9-8-1967 , that (I) (we) last saw the deceased alive on 9-8-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 9-8-67		23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ	
23D. ADDRESS M.D. 5912 Cross Country Blvd; Baltimore		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/10/1967		24C. NAME OF CEMETERY or CREMATORY Hebrew Young Mens		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED SEP 12 1967		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8696		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8696	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Abraham Blum		
2. DATE AND HOUR OF DEATH 9-8-67 7.30 A.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND 42 Sinai Hospital of BAL.		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
6. STREET ADDRESS (If rural, give location) 3219 Ingleside Ave. #15			7. CITIZEN OF WHAT COUNTRY? USA		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-8-07	9. AGE (In years lost birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
11. BIRTHPLACE (State or foreign country) Lithuania			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Chaim David Blum			14. MOTHER'S MAIDEN NAME Gittel?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-28-3691		
17. INFORMANT Leah Blum			ADDRESS 3219 Ingleside Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Acute Cardio-Respiratory Arrest probably due to thrombosis of vessels of Brain Stem.			INTERVAL BETWEEN ONSET AND DEATH 15 min.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ca. metastatic to Cerebellum from unknown origin			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 9-6-67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic Ca. to Cerebellum		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 9-5-1967 to 9-8-1967 , that (I) (we) last saw the deceased alive on 9-8-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jorge Ordonez			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Jorge Ordonez			23D. ADDRESS Sinai Hospital of BAL.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/67		24C. NAME OF CEMETERY OR CREMATORY Bnai Reuben	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. (State) Md.		24F. (Country) USA	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Sal ...	
25D. ADDRESS ...		25E. ADDRESS ...		25F. ADDRESS ...	

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Handwritten text in the lower middle section, possibly a signature or a block of descriptive text.

Handwritten text in the lower section, including a signature that appears to be "R. [illegible]".

Handwritten text at the bottom of the page, including a date or reference number.

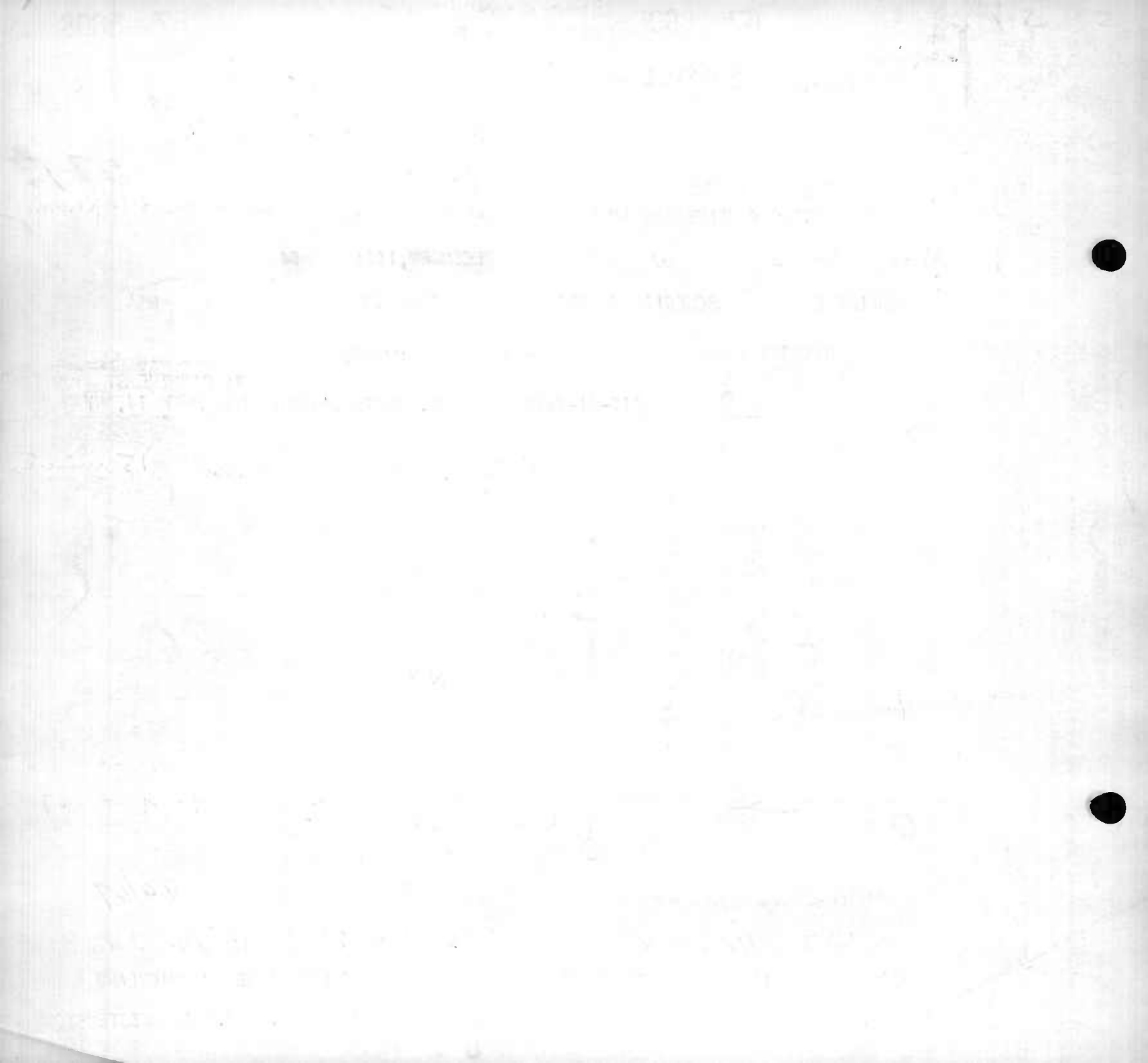
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8697 CERTIFICATE OF DEATH					Registered No. 67 8697				
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Levin, Raymond					2. DATE AND HOUR OF DEATH 9-9-67 11:20 PM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital Inc. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore. 15 Maryland					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City 53-00 D. STREET ADDRESS (If rural, give location) 3919 Southern Cross Drive				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 8-16-1917	9. AGE (In years last birthday) 50	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME DAVID LEVIN				14. MOTHER'S MAIDEN NAME MOLLIE LEASUREX					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-16-9238		17. INFORMANT MRS. EVELYN LEVIN 3919 SOUTHERN CROSS BLVD					
18. 331X1+260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 8 hours				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ?					(B) ?				
					(C) Hypertension. Diabetes mellitus				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9 PM 9/9 1967 to 11:20 PM 9/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Juan L. Roque					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/10/67		
23C. PHYSICIAN'S NAME (Type) JUAN L. ROQUE		23D. ADDRESS SINAI HOSPITAL. BALTO. 15.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/11/67		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BOWLEYS LANE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
67 8698					CERTIFICATE OF DEATH					Registered No. 67 8698									
BIRTH NO.										M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Charles SAMUELS										2. DATE AND HOUR OF DEATH 9-9-67 9 a M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION 91 LEVINDALE AGED HOME GREENSPRING & BELVEDERE AVES										A. STATE Md B. COUNTY Baltimore									
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore									
										D. STREET ADDRESS (If rural, give location) Levindale Hebrew Home & Infirmary									
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH DECEMBER, 1882		9. AGE (In years last birthday) 84		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE				10B. KIND OF BUSINESS OR INDUSTRY SCHERLIS & KATZ				11. BIRTHPLACE (State or foreign country) LITHUANIA				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME UNKNOWN										14. MOTHER'S MAIDEN NAME UNKNOWN									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 217-01-4496					17. INFORMANT MRS. BERTE D'ARRIGO NEW YORK 14, NY									
18. 465 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) Acute Pulmonary Embolism DUE TO					INTERVAL BETWEEN ONSET AND DEATH 15 minutes				
										(B) _____ DUE TO									
										(C) _____ DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
										20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 3-11-1963 to 9-9-1967 , that (I) (we) last saw the deceased alive on 9-9-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Myung Sun Yoon										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 9/9/67				
23C. PHYSICIAN'S NAME (Type) MYUNG SUN YOON										M.D. Singai Hospital of Baltimore Inc.					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 9/11/67					24C. NAME OF CEMETERY or CREMATORY ADATH JESHURUN					24D. LOCATION (City, town, or county) (State) BOWLEYS LANE MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967					25B. NAME OF REGISTRAR Paul E. Taylor					25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD					ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8699	
BIRTH NO. 10		67 8699	
M.E. CASE NO.		1. NAME OF DECEASED DEMO, YETTA	
(Type or Print)		2. DATE AND HOUR OF DEATH 9/9/67 1:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-17	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2420 W. GARRISON AVE	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED (Specify) Unwed	8. DATE OF BIRTH 6/15/00
9. AGE (In years lost birthday) 67		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10B. KIND OF BUSINESS OR INDUSTRY DRESS SHOP	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Simon Mayer Bank		14. MOTHER'S MAIDEN NAME Mrs. Golda	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Donald H. Dembo - 6103 Cypress Terrace		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Cardiac arrest - asystole DUE TO Myocardial Infarction DUE TO ASCVD		INTERVAL BETWEEN ONSET AND DEATH 1 hour 3 d	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/6 1967 to 9/9 1967 , that (I) (we) lost saw the deceased olive on 9/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Kurt P. Sligar, MD		23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) KURT SLIGAR		23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/10/67	
24C. NAME OF CEMETERY OR CREMATORY Onsake Emerald		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS 6010 Kent Rd.	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8700

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILEY BROOKS

2. DATE AND HOUR PRONOUNCED DEAD

September 6, 1967 1:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home and Hospital D.OA.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Harford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Edgewood Arsenal

D. STREET ADDRESS (If rural, give location)

Co. A. Edgewood Arsenal

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

Jan. 11, 1940,

9. AGE (In years last birthday)

27

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Soldier

10B. KIND OF BUSINESS OR INDUSTRY

US Army

11. BIRTHPLACE (State or foreign country)

Houston, Texas

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Julia (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

1962-67

16. SOCIAL SECURITY NO.

461-58-5210

17. INFORMANT

U.S. Army 201 File

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Craniocerebral injuries

(A) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Orleans St. near Belnord Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

6 67 1:30 a.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject was driver in auto into fixed object

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 6, 1967

23A. BURIAL CREMATION, REMOVAL

Burial

23B. DATE

Sept. 8, 1967

23C. NAME OF CEMETERY or CREMATORY

Cemetery Beautiful

23D. LOCATION

(City, town, or county)

Houston, Texas

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 12 1967

R. S. Fisher, M.D.

Lee A. Patterson & Son, Perryville, Md.

Handwritten signature

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8701

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT FREEMAN

2. DATE AND HOUR PRONOUNCED DEAD

September 6, 1967 1:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE California

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Berkley

D. STREET ADDRESS (If rural, give location)

2707 Maple Ave

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Feb. 11, 1946

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

U.S. Army

10B. KIND OF BUSINESS OR INDUSTRY

Soldier

11. BIRTHPLACE (State or foreign country)

New Orleans, La.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert E. Freeman Jr.

14. MOTHER'S MAIDEN NAME

Gwendolyn Hardy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

Nov. 22, '66 - 1967

16. SOCIAL
SECURITY NO.

562-62-2200

17. INFORMANT

Army Records

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Orleans st. near Belnord Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9 6 67 1:30 a.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject was passenger in auto into
fixed object

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher, M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

September 6, 1967

23A. BURIAL CREMATION,
REMOVED

Burial

23B. DATE

Sept. 8, 1967

23C. NAME of CEMETERY or CREMATORY

Mountain View Cemetery

23D. LOCATION (City, town, or county)

Berkley, California

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Lee A. Patterson & Son, Perryville, Md.

ADDRESS

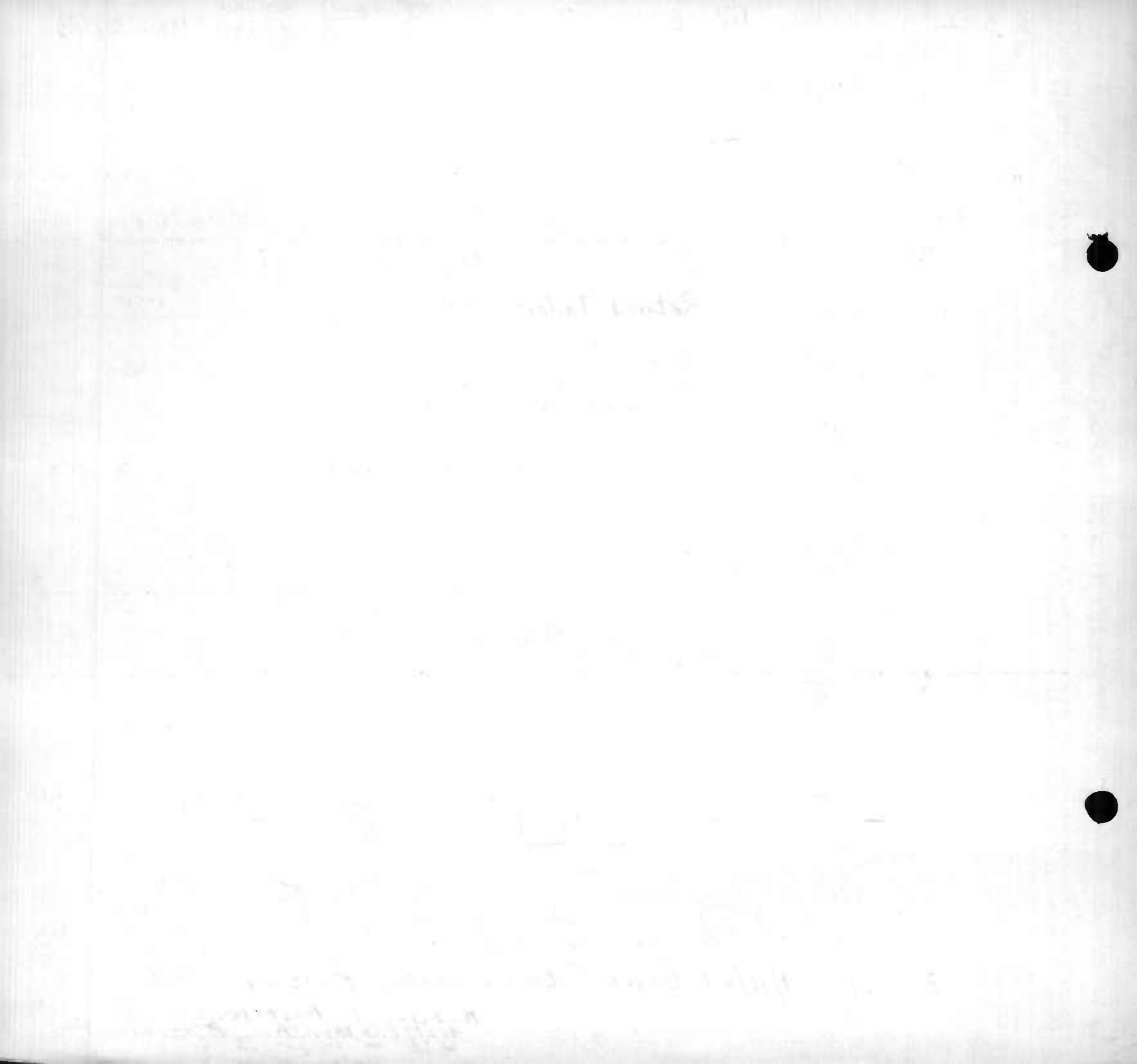


W. A. G. Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 8702
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 8702 CERTIFICATE OF DEATH </div>										
<div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED <small>(Type or Print)</small> Peter Christauntas </div> <div> 2. DATE AND HOUR OF DEATH 9-8-67 11 37 P.M. </div> </div>										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital </div> <div> 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City 26-02 D. STREET ADDRESS (If rural, give location) 4227 Nicholas Ave. </div> </div>										
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/25/99	9. AGE (In years lost birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor			10B. KIND OF BUSINESS OR INDUSTRY Retired Tailor		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Chris P. Tountas					14. MOTHER'S MAIDEN NAME —					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-09-4410		17. INFORMANT Hospital chart					
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small> II. ANTECEDENT CAUSES <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</small>					(A) DUE TO <u>Carcinoma of prostate with metastases</u> (B) DUE TO <u>—</u> (C) DUE TO <u>—</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None										
19A. DATE OF OPERATION None			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —					
21D. TIME OF INJURY (APPROX.) —			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —					
22. I certify that (this hospital) attended the deceased from 8/31/1967 to 9/8/1967, that (I) last saw the deceased alive on 9/8/1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Michael J. Prendergast</i>								23B. DATE SIGNED 9/8/67		
23C. PHYSICIAN'S NAME (Type) MICHAEL J. PRENDERGAST								23D. ADDRESS University Hospital Balto MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967			25B. NAME OF REGISTRAR Nicholas T. Matthews			25C. FUNERAL DIRECTOR Nicholas T. Matthews				
						ADDRESS 4027 Eastern Ave, Baltimore, Md.				



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L-235

BIRTH NO. 66-20147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Sue BELINDA LOGSDON 2. DATE AND HOUR PRONOUNCED DEAD September 7, 1967 6:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 707 Pontiac Avenue 25-04

5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single 8. DATE OF BIRTH Sept. 18, 1966 9. AGE (In years last birthday) 11 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Ronald G. Logsdon 14. MOTHER'S MAIDEN NAME Patricia Moody

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Ronald Logsdon - same

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH (A) Right hemothorax DUE TO

II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Laceration of heart DUE TO

(C) Blunt chest injury

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 21C. WHERE DID INJURY OCCUR? O'Donnell St. and Highland Ave.

21D. TIME OF INJURY (APPROX.) 9-7-67 5:45 P. 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X 21F. HOW DID INJURY OCCUR? Passenger in auto-auto collision 26-09

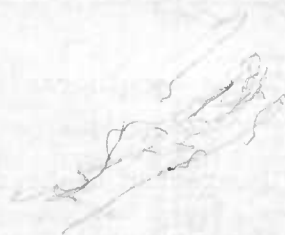
22. I certify that I held an Inquiry Inspection Autopsy X and that on this basis, death in my opinion resulted from: Natural causes Accident X Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER X ASSOCIATE MEDICAL EXAMINER DATE SIGNED September 8, 1967

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE Sept. 11, 1967 23C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park 23D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A.A.Co., Md.

24A. DATE REC'D BY HEALTH DEPT. SEP 12 1967 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS George J. Gonce-4001 Ritchie Hgwy., Baltimore

1861129 6 1 0 0 0 0 7 2 3



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 8704		67 8704		67 8704	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SINGER, MARIE EVA		2. DATE AND HOUR OF DEATH 9/10/67 5:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP OF BALTO.		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MD B. COUNTY			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	
8. DATE OF BIRTH 1896 12/1/22		9. AGE (In years lost birthday) 74		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) USA-MD.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME JACOBENA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HERMAN SINGER ADDRESS SAME	
18. 433.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) VENTRICULAR FIBRILLATION DUE TO (B) ARTERIOSCLEROTIC CVD DUE TO (C) A-V DISSOC. E NODAL RHYTHM		INTERVAL BETWEEN ONSET AND DEATH 15 MIN.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/3/67 to 9/10/67, that (2) (we) last saw the deceased alive on 9/10/67 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE Edward R. Cohen M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE/SIGNED 9/10/67	
23C. PHYSICIAN'S NAME (Type) EDWARD R. COHEN M.D.				23D. ADDRESS SINAI HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME OF CEMETERY or CREMATORY Sinai Israel Balto Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC ADDRESS	

Letter from Sinai Hospital

9-18-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

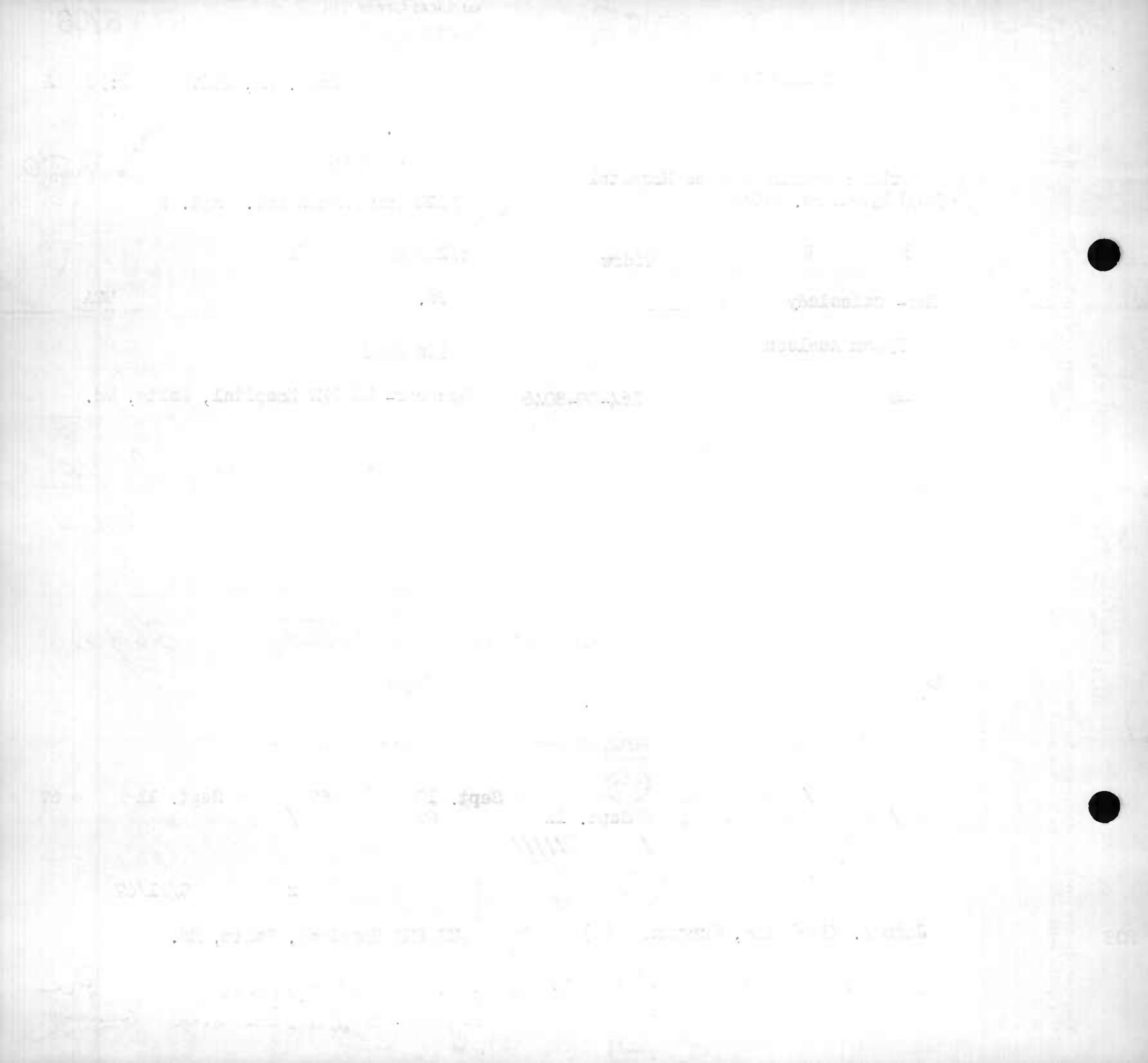
BIRTH NO. 67 8705				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8705	
1. NAME OF DECEASED (Type or Print) JEANETTE B. GREENBERG				2. DATE AND HOUR OF DEATH 9/9/1967 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HASINAI HOSP				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-19 D. STREET ADDRESS (If rural, give location) 5707 HIGHGATE DRIVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JULY 4, 1899	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB			14. MOTHER'S MAIDEN NAME ETHEL				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT MAX GREENBERG		ADDRESS SAME	
18. 260X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Arteriosclerotic Heart Disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 years	
				(B) Diabetes Mellitus DUE TO		10 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from Sept. 1963 to Sept. 9 1967 , that (I) (we) last saw the deceased alive on July 1967 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) did not view the body after death.							
23A. SIGNATURE Morris B. Schreiber				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/10/67	
23C. PHYSICIAN'S NAME (Type) MORRIS B. SCHREIBER				23D. ADDRESS M.D. 1519 W. Lombard St. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/10/67		24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN		24D. LOCATION (City, town, or county) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc		ADDRESS Garrison md	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M-260				67 8706				67 8706			
M.E. CASE NO.				Tillie Mazor				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				Sept. 11, 1967 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Md.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
US Public Health Service Hospital 3100 Wyman Pk. Drive				Baltimore				27-20			
D. STREET ADDRESS (If rural, give location)				3120 Parkington Ave. Apt. F							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.				
F	W	Widow	6/28/06	61							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Hwf- saleslady						Pa.			USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Hyman Adelson				Ida Bond							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				164-09-8046		Records- US PHS Hospital, Balto, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Myocardial Infarction (B) A.S.C.V.D. (C)				20 hrs. 10 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes Mellitus				20 yrs.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
0				No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from Sept. 10 1967 to Sept. 11 1967, that (I) (we) last saw the deceased alive on Sept. 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
John A. Kibelstis								9/11/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
John A. Kibelstis, Surgeon (R)				US PHS Hospital, Balto, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)			
Burial		9/12/67		Mt Lebanon		Corrydale		Pa			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
SEP 12 1967		Robert E. Taylor, M.D.		Sylvan S. Lewis & Son, INC		Garrison		Md			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8707	
BIRTH NO. 67 8707		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Kathleen Laven		2. DATE AND HOUR OF DEATH Sept. 7, 1967 10:20p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 91 Montebello State Hospital		A. STATE Maryland		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		14-03	
		D. STREET ADDRESS (If rural, give location) 1829 Eutaw Place			
5. SEX female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1/17/01	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife - Seamstress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Wilson Wood		14. MOTHER'S MAIDEN NAME Fanny Payne		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-1998		17. INFORMANT Hospital Chart Maurice Lauer-1829 Eutaw Place	
18. 203X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Multiple Myeloma		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 20 1967 to Sept. 7 1967 , that (I) (we) lost saw the deceased alive on Sept. 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cesar J. Pellerau M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 7, 1967	
23C. PHYSICIAN'S NAME (Type) Cesar J. Pellerau M.D.		23D. ADDRESS Montebello State Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-11-67	24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR John B. Johnson		25C. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hghts. Ave	

[illegible]

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.
67 8708		CERTIFICATE OF DEATH		286084 67 8708
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Carlton Price XXX SR.		Sept. 8, 1967 1:03 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI Hospital		A. STATE Maryland B. COUNTY Baltimore		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
		D. STREET ADDRESS (If rural, give location) 1808 Chilton Street # 18		
5. SEX	6. RACE	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH	9. AGE (In years lost birthday)
Male	White		11-23-03	63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman			Easton, Maryland	U.S.A
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Willard Price		Lizzie S. Woodward		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
YES		WW 2	Thelma E. Price-1808 Chilton Street	
		212-05-9886		
18. 331X1		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Massive cerebral hemorrhage DUE TO		
ANTECEDENT CAUSES		(B) Hypertension DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Blood dyscrasia		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 10:45 PM 9/8/67 to death 9/8/67 that (I) (we) last saw the deceased alive at 1:00 AM Sept 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
Michael J. Bann				9/8/67
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
		M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	9-12-67	Woodlawn Cemetery	Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS
SEP 12 1967	Ellsworth Armacost	-4600 Liberty Hghts. Ave		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">67 8709</p> <p style="font-size: 18pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p>		<p>Registered No. 67 8709</p>	
<p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print)</p> <p style="font-size: 18pt; text-align: center;">REINHARDT, WILLIAM</p>		<p>2. DATE AND HOUR OF DEATH</p> <p style="font-size: 18pt; text-align: center;">SEPTEMBER 10, 1967 8:45A.M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 24pt; text-align: center;">40</p> <p style="font-size: 18pt; text-align: center;">ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY HOWARD COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p style="font-size: 18pt; text-align: center;">ELLICOTT CITY 63-00</p> <p>D. STREET ADDRESS (If rural, give location)</p> <p style="font-size: 18pt; text-align: center;">13 AMHERST AVENUE</p>	
<p>5. SEX</p> <p style="font-size: 18pt; text-align: center;">MALE</p>	<p>6. RACE</p> <p style="font-size: 18pt; text-align: center;">WHITE</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)</p> <p style="font-size: 18pt; text-align: center;">MARRIED</p>	<p>8. DATE OF BIRTH</p> <p style="font-size: 18pt; text-align: center;">07-10-93</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 18pt; text-align: center;">RETIRED</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>9. AGE (In years lost birthday)</p> <p style="font-size: 18pt; text-align: center;">74</p>
<p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 18pt; text-align: center;">MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 18pt; text-align: center;">USA</p>	
<p>13. FATHER'S NAME</p> <p style="font-size: 18pt; text-align: center;">MARTIN DEC'D</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 18pt; text-align: center;">MAGGIE (SMYTH) DEC'D</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 18pt; text-align: center;">NO</p>		<p>16. SOCIAL SECURITY NO.</p> <p style="font-size: 18pt; text-align: center;">215-05-9167</p>	
<p>17. INFORMANT</p> <p style="font-size: 18pt; text-align: center;">WILKENS & CATON AVES</p>		<p>ADDRESS</p> <p style="font-size: 18pt; text-align: center;">ST. AGNES RECORDS BALTO., MD. 21229</p>	
<p>18. I</p> <p style="font-size: 18pt; text-align: center;">16211</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="font-size: 18pt; text-align: center;">DUE TO</p> <p style="font-size: 24pt; text-align: center;">① Bronchogenic carcinoma of R. upper bronchus.</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> <p style="font-size: 18pt; text-align: center;">DUE TO</p> <p style="font-size: 24pt; text-align: center;">② Superior vena cava syndrome secondary to above.</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION</p> <p style="font-size: 18pt; text-align: center;">2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p> <p style="font-size: 18pt; text-align: center;">YES</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from AUGUST 29, 19 67 to SEPT. 10, 19 67, that (X) (we) last saw the deceased alive on SEPT. 10, 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p style="font-size: 18pt; text-align: center;">Pablo F. Dibos</p> <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="font-size: 18pt; text-align: center;">DR. PABLO DIBOS</p>		<p>23D. ADDRESS</p> <p style="font-size: 18pt; text-align: center;">ST. AGNES HOSPITAL BALTIMORE, MD. 21229</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 18pt; text-align: center;">Burial</p>	<p>24B. DATE</p> <p style="font-size: 18pt; text-align: center;">9/13/67</p>	<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p style="font-size: 18pt; text-align: center;">Baltimore National</p>	<p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 18pt; text-align: center;">Baltimore, Maryland</p>
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="font-size: 18pt; text-align: center;">SEP 12 1967</p>	<p>25B. NAME OF REGISTRAR</p> <p style="font-size: 18pt; text-align: center;">Pablo F. Dibos</p>	<p>25C. FUNERAL DIRECTOR</p> <p style="font-size: 18pt; text-align: center;">McGully Funeral Home</p>	<p>ADDRESS</p> <p style="font-size: 18pt; text-align: center;">237 Patapsco Ave. 21225</p>

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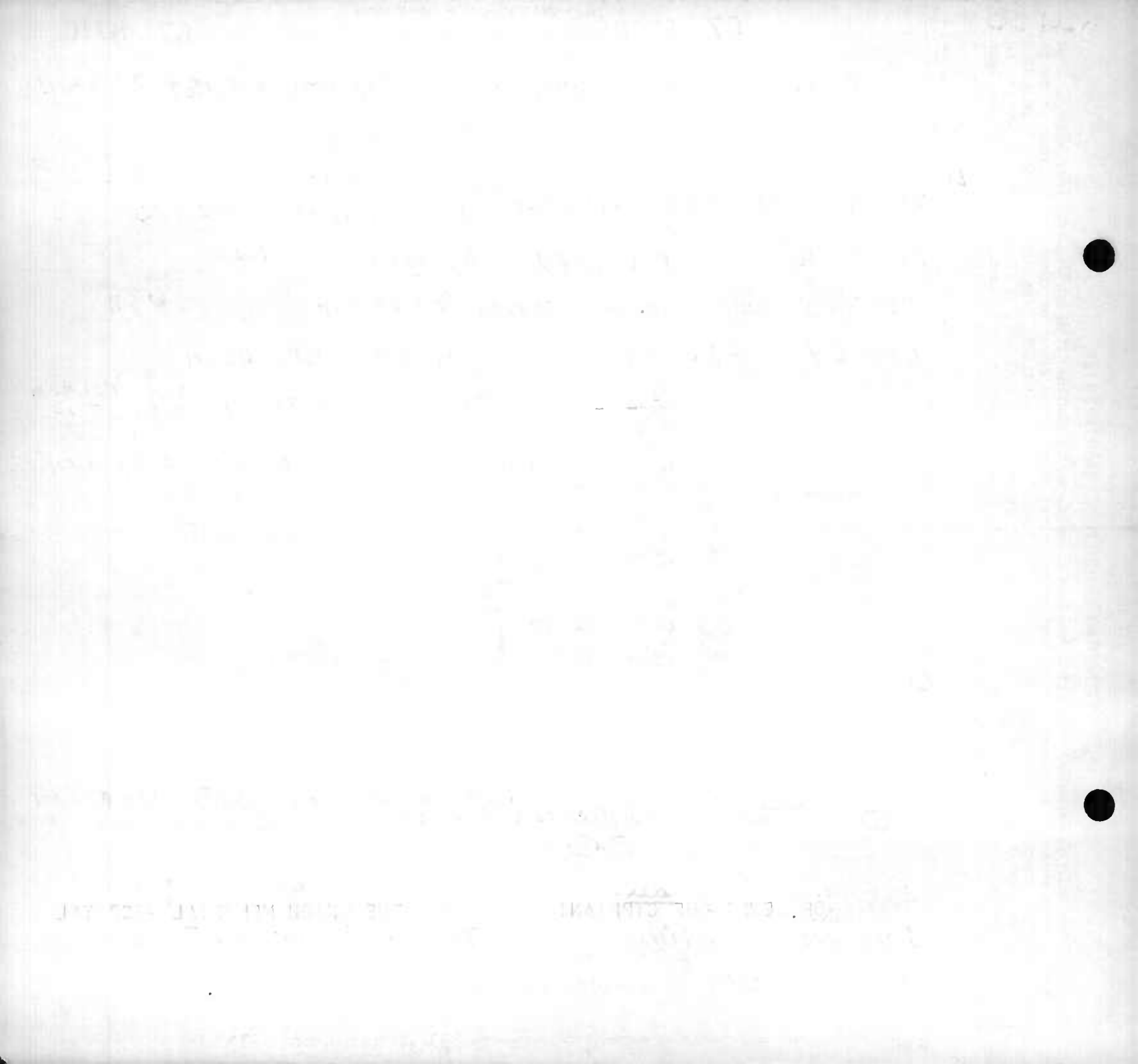
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

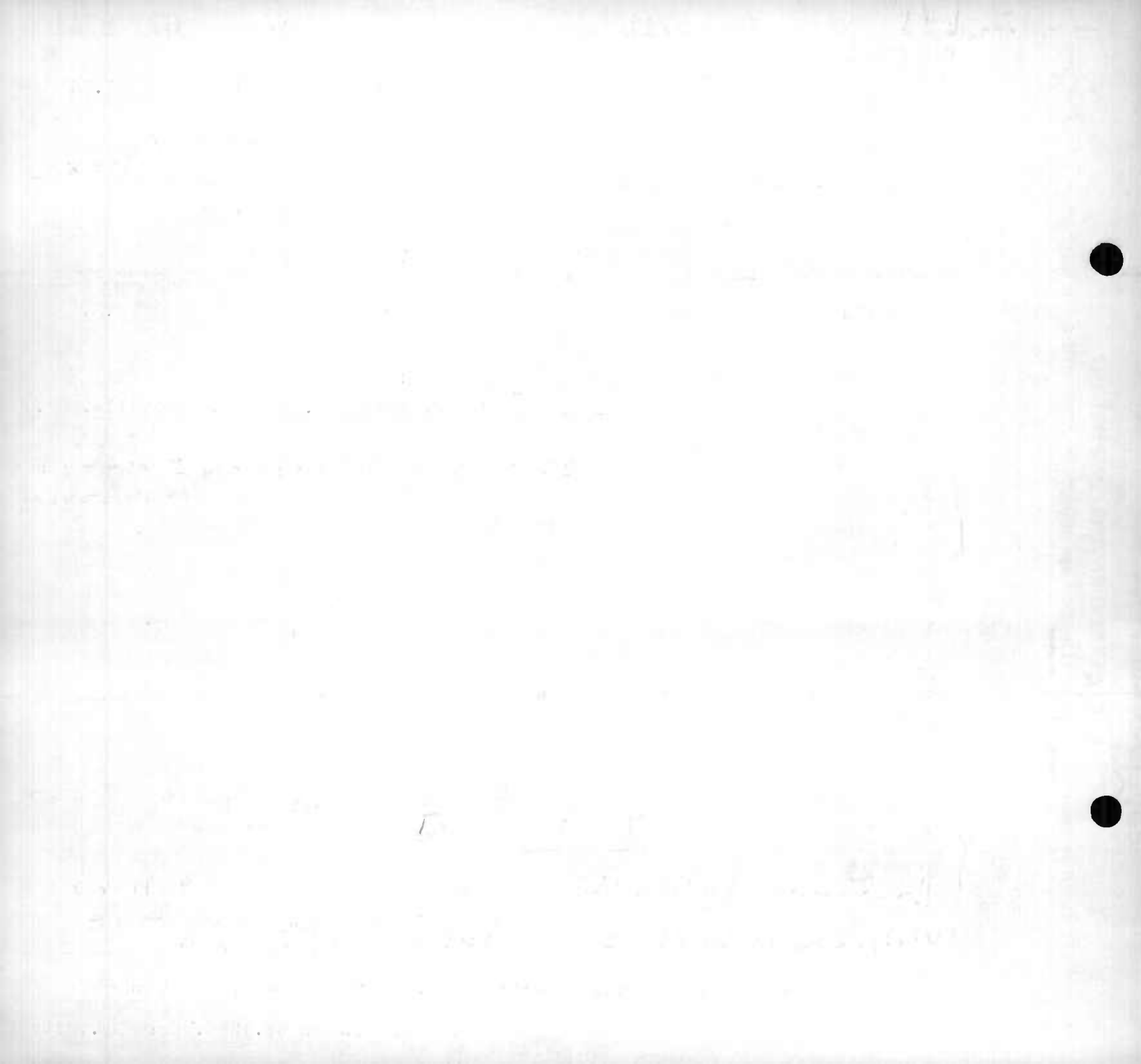
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8710	
BIRTH NO. 67 8710		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH SEPTEMBER 8, 1967 3:32 P.M.	
1. NAME OF DECEASED (Type or Print) DOOLEY ROY EDGAR		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-03 D. STREET ADDRESS (If rural, give location) 3010 PELHAM AVE. #13	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 11/19/04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Foreman		10B. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Electric	9. AGE (In years last birthday) 62 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DOOLEY GEORGE		14. MOTHER'S MAIDEN NAME NORA DAVIDSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-05-5734	17. INFORMANT MAR RUTH BURNLEY ADDRESS 3016 PELHAM AVE. #13
18. 163X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF LUNG 2 1/2 MONTHS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>September 7</u> 19 <u>67</u> to <u>SEPTEMBER 8</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>SEPTEMBER 8</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.			
23A. SIGNATURE Enrique Cipriani		23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) DR. ENRIQUE CIPRIANI		23D. ADDRESS THE UNION MEMORIAL HOSPITAL 33rd and Calvert STS.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/12/67	24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park	24D. LOCATION (City, town, or county) (State) Elkridge, Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967	25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8711				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8711	
1. NAME OF DECEASED (Type or Print) CORA V. HINES				2. DATE AND HOUR OF DEATH Sept. 10, 1967 7.55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3223 Burleith Avenue				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore County C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pikesville 53-00 D. STREET ADDRESS (If rural, give location) Stone Chapel Lane 21208			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH about 1876	9. AGE (In years last birthday) about 91	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO no		16. SOCIAL SECURITY NO. J-1 218-52-2494		17. INFORMANT: Employer ADDRESS Miss Josephine P. Howard, Pkesville, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion DUE TO A.C.V.D.				CAUSE OF DEATH Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 3 weeks UNKNOWN	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-12 19 65 to 9-10 19 67 , that (I) (we) last saw the deceased alive on 9-9- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE William H. Watts M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-11-67	
23C. PHYSICIAN'S NAME (Type) William H. Watts M.D.				23D. ADDRESS 1514 Arlington Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/12/67	24C. NAME of CEMETERY or CREMATORY Carver Memorial Cemetery		24D. LOCATION (City, town, or county) (State) near Laurel, Maryland			
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co. 108W. North Av., City 1			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE RELEASED ON APPROVAL BY DR. KORNBLUM OF THE M.E. OFFICE

BIRTH NO. 67 8712		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8712	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) LEONARD WHITE		
2. DATE AND HOUR OF DEATH 9-6-67 7:45 AM			3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital 601 N. Broadway Baltimore, Maryland		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1016 N. Dallas Street		
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 3/04/18	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nathan White			14. MOTHER'S MAIDEN NAME CARPENTER, DRUCILLA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Elizabeth Phillip Lusby, Md.		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Recent & remote anteroseptal myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Recent & remote anteroseptal myocardial infarction (B) myocardial infarction (C) myocardial infarction INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-6-67 19 to 9-6-67 19, that (I) (we) last saw the deceased alive on 9-6-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Michael Vincent M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9/06/67		
23C. PHYSICIAN'S NAME (Type) G. Michael Vincent		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 9-10-67	24C. NAME OF CEMETERY or CREMATORY St. John Ch. Cem		24D. LOCATION (City, town, or county) (State) Lusby, Calvert Md.	
25A. DATE REC'D. BY HEALTH DEPT. SEP 12 1967	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Robert E. Taylor		ADDRESS Prince Frederick Md	

G. Michael Vincent

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8713		67 8713		67 8713	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Margaret H. Hess		9-9-67 2:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
37 Mercy Hospital		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore City		26-11	
		D. STREET ADDRESS (If rural, give location)			
		708 S. Clinton St. #21224			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
FEMALE	Caucasian	married	9-12-95	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY	
Cleaning at Home		Maid	Baltimore City, MD.	United States	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
James Mullaney		Elizabeth Westig			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		220-18-4883A	FRANK G. HESS 708 S. CLINTON ST. BALTO. MD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I. 384X1		A. Brochopneumonia		days	
		B. Complicated by renal lithiasis		years	
		C. cholelithiasis H.A.S. (V.I.)			
ANTECEDENT CAUSES		D. pending: microscopic exam on autopsy specimen			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		yes	yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 9-9-67 to 9-9-67, that (I) (we) last saw the deceased alive on 9-9-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Philip H. Moore		9-9-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PHILIP H. MOORE		MERCY HOSPITAL.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
BURIAL	9-12-67	SACRED HEART CEM.	7401 GERMAN HILL RD. BALTO. CO., MD.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
SEP 12 1967	Robert E. J. J. J.	Charles S. J. J.	901 S. CONKLING ST. BALTO., 24, MD.		

Wm. H. Moore

James Mulligan
George H. Moore
James H. Moore

James H. Moore
George H. Moore
James H. Moore

James H. Moore

James H. Moore

James H. Moore

James H. Moore

James H. Moore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. <u>67 8714</u>
BIRTH NO. <u>67 8714</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		6. DATE AND HOUR OF DEATH <u>8 Sept. 1967</u> <u>9⁰⁵</u> <u>A.M.</u>		
1. NAME OF DECEASED (Type or Print) <u>HENRIETTA SCHMIEDICKE</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>35 Church Home and Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Dundalk</u> D. STREET ADDRESS (If rural, give location) <u>#10, Dundalk Bldg.</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>29 Sept., 1887</u>	9. AGE (In years last birthday) <u>79</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ferdinand Steinbach</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Brettschneider</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216003-5004 D</u>	17. INFORMANT ADDRESS <u>Ferdinand Smith, 934 North Hill Rd. 21218</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1</u> <u>Pulmonary Edema</u> <u>Myocardial Infarction</u> <u>Anterioductic Coronary Dis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>HOURS</u> <u>5-10 years</u>
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (his hospital) attended the deceased from <u>Jan. 8</u> 19 <u>66</u> to <u>9/6</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/6</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Paul G. Koukoulas</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>9/11/67</u>
23C. PHYSICIAN'S NAME (Type) <u>Paul G. Koukoulas</u>		23D. ADDRESS <u>6511 O'Donnell St.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>	24B. DATE <u>9-11-67</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1967</u>	25B. NAME OF REGISTRAR <u>67 8714</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Wilrich Funeral Home, Dundalk, Md.</u>		

Polymers & Resins
Superficial Inspection
Artificial Polymer

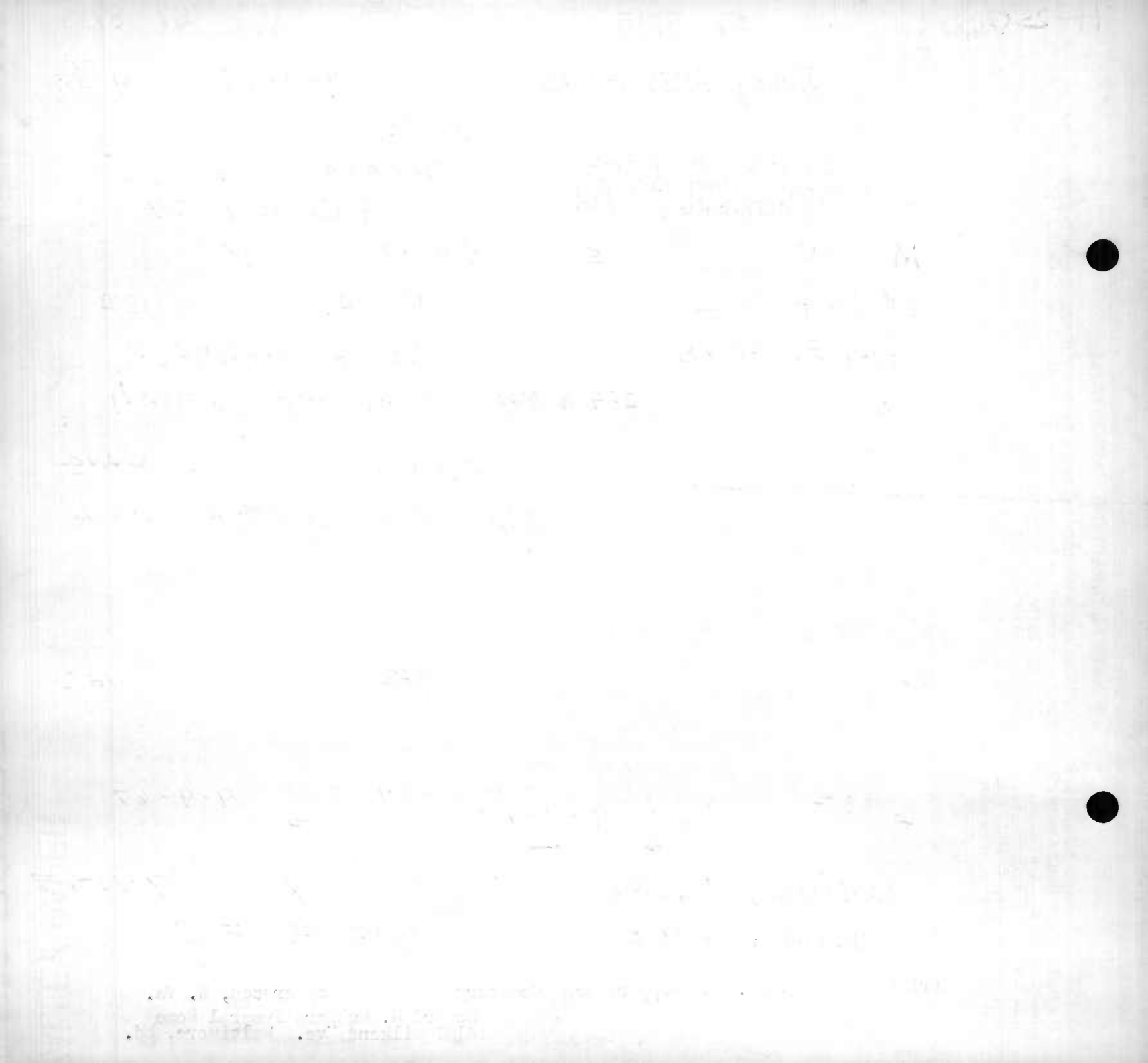
Paul C. Fournier
Gene C. Fournier

Gene C. Fournier

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

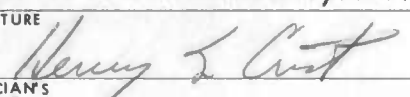
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8715	
BIRTH NO. 67 8715		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Jimmy ALLEN HICKS		2. DATE AND HOUR OF DEATH 9-9-67 9 30 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE W. VA. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 28 USPHS HOSPITAL WYMAN PARK DRIVE BALTIMORE, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) OCEANA V-45			
		D. STREET ADDRESS (If rural, give location) P.O. BOX 24			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 5-4-49	9. AGE (In years lost birthday) 18	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) "W." VA.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME RAY E. HICKS		14. MOTHER'S MAIDEN NAME NELLIE HAMMACK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 234-76-2849		17. INFORMANT ADDRESS USPHS Hosp RECORDS	
18. 204.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEPTICEMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO SEPTICEMIA (B) DUE TO MYELOGENOUS Leukemia (C)		INTERVAL BETWEEN ONSET AND DEATH DAYS Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8-11-67 19 to 9-9-67 19, that we (we) last saw the deceased alive on 9-9-67 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) not view the body after death.					
23A. SIGNATURE William L. Wilkie M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9-10-67	
23C. PHYSICIAN'S NAME (Type) William L. WILKIE		23D. ADDRESS SAME AS # 3			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 13		24C. NAME OF CEMETERY or CREMATORY Koppers ton Cemetery	
				24D. LOCATION (City, town, or county) (State) Kopperston, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard Funeral Home 4107 Wilkens Ave. Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8716	
BIRTH NO. 67 8716		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George Cullen		Sept. 7, 1967 4:50 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.			
US Public Health Service Hospital 3100 Wyman Park Drive		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4010 Falls Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	W	Married	12/28/16	50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Asst. Eng.		Seafaring		W. Va.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Cullen			Elizabsth Mc Lean		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		362-18-0768		Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Carcinoma of stomach		5 yrs.	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug. 29 19 67 to Sept. 7 19 67 , that (I) (we) last saw the deceased alive on Sept. 7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				9/8/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Henry S. Crist, SA Surg (R)		US PHS Hospital, Balto, Md.			
24A. BURIAL CREATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	9/11/67	Bicknell Odd Fellows Cem		Bicknell, Indiana	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 12 1967		Robert E. Taylor		Howard H. Hubbard Funeral Home 4107 Wilkens Ave. Baltimore, Md. 21229	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8717</u>	
BIRTH NO. <u>67 8717</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Josiah Young</u>		2. DATE AND HOUR OF DEATH <u>9-8-67</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>1434 Presstman Street</u> <u>Balto., Md. 21217</u>		A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> D. STREET ADDRESS (If rural, give location) <u>1434 Presstman Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>2-25-94</u>	9. AGE (In years lost birthday) <u>73</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George W. Young</u>			14. MOTHER'S MAIDEN NAME <u>Henrietta Harris</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218055965</u>	17. INFORMANT <u>Lina Finley 1434 Presstman St. - sister</u>		ADDRESS
18. <u>331 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterio-sclerosis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos - undetermined</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 10 1967</u> to <u>Sept 8 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 8 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James S. Julian Jr.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>JAMES S. JULIAN, JR.</u>		23D. ADDRESS <u>511 N. Schroeder St Baltimore MD 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9-13-67</u>	24C. NAME of CEMETERY or CREMATORY <u>Baltimore Nat'l. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Kelson Funeral Home 1348 Calhoun St.</u>	

2-25-4

Charles H. H. H. H.
H. H. H. H. H.

2-25-4 10 11 12

James S. Allen, Jr.
James S. Allen, Jr.

2-25-4 10 11 12

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FUNERAL DIRECTOR: IMPORTANT

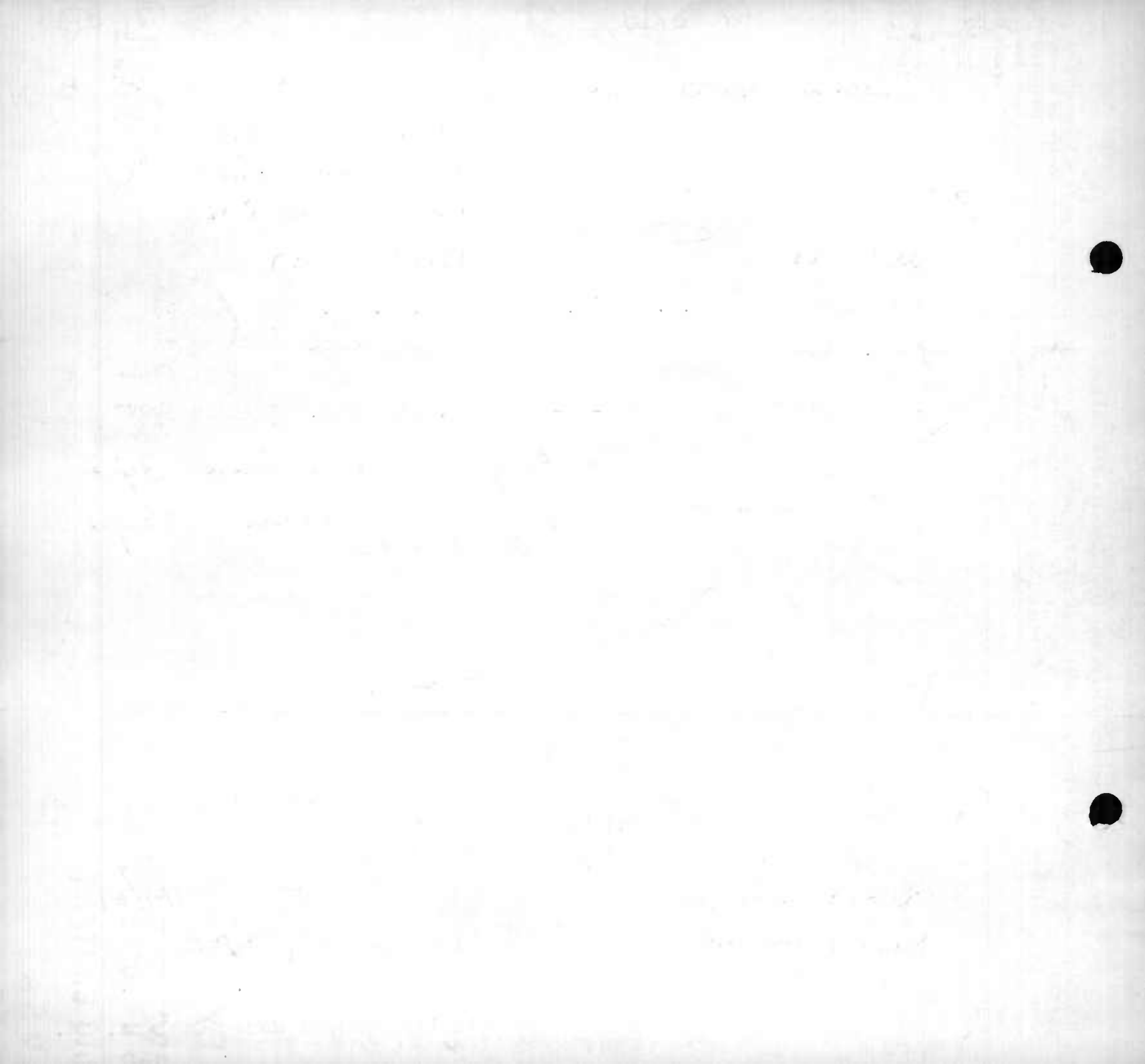
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8718		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8718	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Nancy Louise Eder		2. DATE AND HOUR OF DEATH Sept. 6, 1967 7:40 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Cecil Co.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8 US Public Health Service Hospital 3100 Wyman Pk. Drive		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Elkton 57-21			
D. STREET ADDRESS (If rural, give location) 403 Park Circle					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/11/27	9. AGE (In years, last birthday) 39	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Fla.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Phillip Beamer		14. MOTHER'S MAIDEN NAME Jessie Bruce			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-24-7467		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. 20011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Focal embolic encephalitis due to lymphosarcoma		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Non-toxic thyroid nodule		(C) DUE TO		Years	
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 5 1967 to Sept. 6 1967, that (I) (we) last saw the deceased alive on Sept. 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry S. Crist		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/7/67	
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surg (R)		23D. ADDRESS M.D. US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-67		24C. NAME OF CEMETERY or CREMATORY Immaculate Conception Cem.	
24D. LOCATION (City, town, or county) (State) Cherry Hill, Cecil Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Robert E. Jefferson		25C. FUNERAL DIRECTOR PIPPIN-FUNERAL HOME	
				ADDRESS Elkton, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8719	
BIRTH NO. 67 8719		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN ROBERT KING</u>		2. DATE AND HOUR OF DEATH <u>9/7-67</u> <u>6³⁰</u> A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		A. STATE <u>MD</u> B. COUNTY <u>Garrett Co.</u>			
5. SEX <u>M</u> 6. RACE <u>W</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>MT LAKE PARK</u> <u>61-00</u>			
7. <input checked="" type="checkbox"/> MARRIED, <input type="checkbox"/> NEVER MARRIED, <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)		D. STREET ADDRESS (If rural, give location) <u>421 ROANOKE AVE</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		8. DATE OF BIRTH <u>10/21/19</u> 9. AGE (In years last birthday) <u>47</u>	
11. BIRTHPLACE (State or foreign country) <u>Bayard, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John B. King</u>			14. MOTHER'S MAIDEN NAME <u>Susan Swick</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>220-10-1304</u>		17. INFORMANT <u>Mrs. Mae King. see # 4 above</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. If means the disease, injury or complication which caused death.) <u>410X I</u>		CAUSE OF DEATH (A) <u>CONGESTIVE HEART FAILURE</u> DUE TO (B) <u>RHEUMATIC HEART DISEASE</u> DUE TO <u>W M.I. & M.S.</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>25 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> 19 <u>65</u> to <u>9/7</u> 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>9/7</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kurt P Sugar</u>				23B. DATE SIGNED <u>9/7/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>KURT P SUGAR</u>				23D. ADDRESS <u>UNIVERSITY HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/10/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Deer Park Cemetery</u>	
24D. LOCATION <u>Garrett Co.</u>		24E. LOCATION (City, town, or county) (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Minnich Funeral Home</u>	
				ADDRESS <u>Oakland, Md.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8720

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

~~DONALD WIMMER~~ Don Borsey Harvey Wimmer

2. DATE AND HOUR PRONOUNCED DEAD

September 9, 1967 1 ? M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

Virginia

Roanoke

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Roanoke, Virginia

D. STREET ADDRESS (If rural, give location)

810 Tinker Ave., Vinton
1521 Wilson Rd. N. W. Roanoke Va. Va.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

11-25-1949

9. AGE (In years
last birthday)

22 17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

S/A U-S-Coast Guard

10B. KIND OF BUSINESS OR INDUSTRY

U-S-G.

11. BIRTHPLACE (State or foreign country)

Roanoke, Va.

12. CITIZEN OF
WHAT COUNTRY?

U-S-A-

13. FATHER'S NAME

Posey Lester Harvey

14. MOTHER'S MAIDEN NAME

Eva Pilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

3-1967 to 9-8-67

16. SOCIAL
SECURITY NO.

=====

17. INFORMANT

ADDRESS

Father (Posey Lester Harvey -Vinton, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)(A) Carbon Monoxide Poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

off 3400 block Hawkins Pt. Rd.

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9 9 67 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Carbon monoxide poisoning Suicide

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

September 9, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-13-67

23C. NAME of CEMETERY or CREMATORY

Mt. View Cemetery

23D. LOCATION

(City, town, or county)

Vinton, Va.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Thomas J. Kenney, Inc. 1600 Hollins St

ADDRESS

0550

05-01

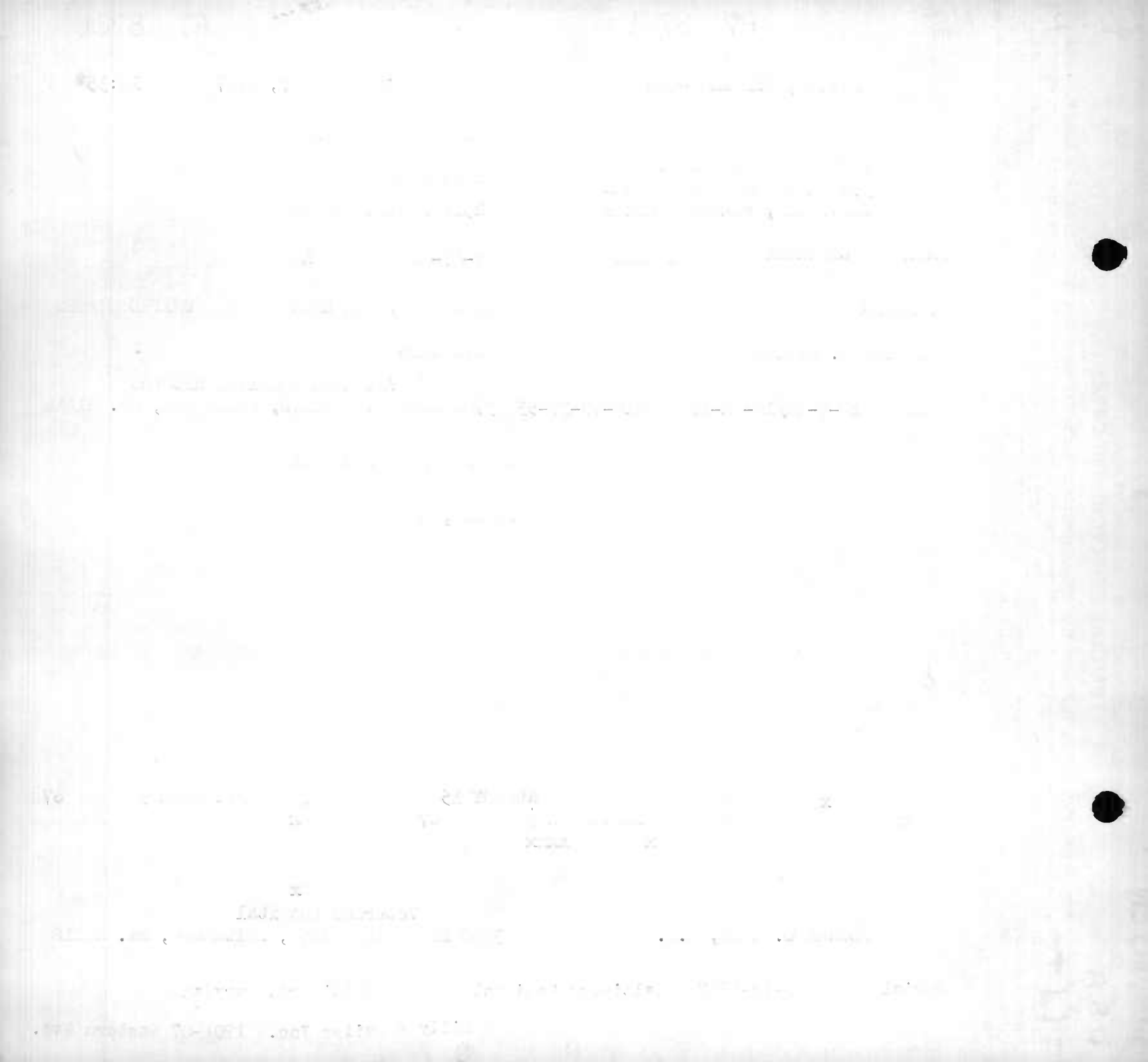
05-01

These findings are available to
the public.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8721	
BIRTH NO. 67 8721		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LYSTON, WILLIAM JOHN		2. DATE AND HOUR OF DEATH SEPTEMBER 9, 1967 10:35 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2518 FOSTER AVENUE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-17-18	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME WILLIAM M. LYSTON		14. MOTHER'S MAIDEN NAME EVA KRUG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10-6-41/10-11-45		16. SOCIAL SECURITY NO. 212-09-37-53		17. INFORMANT ADDRESS VETERANS HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARDIAC INSUFFICIENCY DUE TO (B) CANCER, COLON DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that it (this hospital) attended the deceased from AUGUST 15 19 67 to SEPTEMBER 9 19 67 , that he (we) lost saw the deceased alive on SEPTEMBER 9 19 67 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) not view the body after death.					
23A. SIGNATURE <i>Edward O. Hunt</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/12/67	
23C. PHYSICIAN'S NAME (Type) EDWARD O. HUNT, M.D.		23D. ADDRESS Veterans Hospital M.D. 3900 Loch Raven Blvd, Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-1967		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc, 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8722 CERTIFICATE OF DEATH					Registered No. 67 8722				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) EDWARD CLINTON HAMMOND					2. DATE AND HOUR OF DEATH Sept. 9, 1967 9:50 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium 6116 Bel Air Road Baltimore, Maryland					A. STATE Maryland B. COUNTY Baltimore Co.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bradshaw 53-00				
					D. STREET ADDRESS (If rural, give location)				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 17, 1877	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10B. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Upper Falls, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joshua Hammond					14. MOTHER'S MAIDEN NAME Augusta Ledley				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-38-9090		17. INFORMANT Frank R. Hammond, Upper Falls, Md				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 199.21 Carcinoma of mouth & neck 3 yrs Arteriosclerotic C-V disease					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Aug. 13 1967 to Sept. 9 1967 , that (I) (was) last saw the deceased alive on Sept. 9 1967 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.									
23A. SIGNATURE H. V. Harbold					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept. 11, 1967		
23C. PHYSICIAN'S NAME (Type) Harold V. Harbold					23D. ADDRESS 4706 Harford Road, Baltimore, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 12, 1967		24C. NAME OF CEMETERY or CREMATORY Salem Methodist Cem.		24D. LOCATION (City, town, or county) (State) Upper Falls Balto Md			
25A. DATE RECEIVED BY HEALTH DEPT. SEP 12 1967			25B. NAME OF REGISTRAR Robert E. Harbold		25C. FUNERAL DIRECTOR ADDRESS Howard K. McGomas & Son, Abingdon Md				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8723		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8723	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Stanley Lee Kelly (Kelley) (U)		2. DATE AND HOUR OF DEATH 9-8-67 8:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 92 Baltimore City Jail		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-06 D. STREET ADDRESS (If rural, give location) 2851 West Lafayette Avenue			
5. SEX male	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 9-2-34	9. AGE (In years lost birthday) 33	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) SUREY, VIRGINIA	
13. FATHER'S NAME Stanley Kelly		14. MOTHER'S MAIDEN NAME Alice Kelly		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. 224-40-7880		17. INFORMANT ADDRESS Mrs. Eva Brown 2851 W. Lafayette Ave	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH aortic-sclerotic heart disease & myocardial degeneration (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/1 1967 to 9/8 1967, that (I) (we) last saw the deceased alive on 9/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph R. Liberto		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO		23D. ADDRESS Baltimore City Jail, 401 E. Eager St.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-12-67		24C. NAME OF CEMETERY OR CREMATORY Kelly's Cemetery	
24D. LOCATION		24E. LOCATION (City, town, or county) (State) SUREY, VIRGINIA			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 12 1967		A. R. Kelly		Hyman & Sons, 1701 LAURENS ST	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8724

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)McDuffie
ODELL COPLAND

(COPELAND)

2. DATE AND HOUR PRONOUNCED DEAD

September 2, 1967 3:18 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

615 Lennox Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

2-17-1937

9. AGE (In years
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction Work

11. BIRTHPLACE (State or foreign country)

Simpsonville, S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ODELL COPELAND, SR.

14. MOTHER'S MAIDEN NAME

ELLA MAE JACKSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Eleanor Ost 904 Coppins Court

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stabwound of neck
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

sidewalk

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1800 Block Park Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9-2-67 3:00 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed by unknown assailant

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate

M.D. CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒

September 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-11-67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore,

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.

WALLEN POTHE

2/10/1911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8725

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET Maggie K. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

September 10, 1967 6:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1949 W. Mulberry St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

2/22/1894

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DOMESTIC WORK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MONTGOMERY CO., MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

EDWARD LEAR

14. MOTHER'S MAIDEN NAME

SOPHIA LEAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-32-4374

17. INFORMANT

ADDRESS

Mr. William U. Johnson 1949 W. Mulberry

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive
DISEASE
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-15-67

23C. NAME of CEMETERY or CREMATORY

ARBUTUS MEMORIAL PK.

23D. LOCATION (City, town, or county) (State)

BALTIMORE,

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.

2/23/11

Handwritten signature and date: 2/23/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8726		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8726	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
JAMES CORBET FOSS			September 10, 1967 6:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines 5837 Belair Road			A. STATE Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 21224 1-02		
D. STREET ADDRESS (If rural, give location) 504 S. Streeper Street					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH Feb. 7, 1894	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer, food machinery - retired		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Foss			14. MOTHER'S MAIDEN NAME Mary Rogers		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --- 213-01-9601		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Clayton W. Foss - 6825 Eastbrook Ave. 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Metastatic Carcinoma DUE TO (B) Carcinoma of the Stomach DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 6 yrs.
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 19 66 to Sept 10 1967, that (I) (we) last saw the deceased alive on Sept 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley M.D.			23B. DATE SIGNED 9/11/67		
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley M.D.			23D. ADDRESS 4900 Belair Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/14/67	24C. NAME of CEMETERY or CREMATORY First United Evangelical	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS H. Sander & Sons, Inc., Balto., Md.			

14. *Myrica*
15. *Myrica*

Mr. O. Buckley
1
10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8727		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8727	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELIZABETH LLOYD GIBSON		2. DATE AND HOUR OF DEATH SEPT. 9, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21213	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Nursing Home 6115 Belair Road		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1539 North Broadway	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Jan. ? 1877	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired Amer. Railroad Ex.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard J. Bloxham		14. MOTHER'S MAIDEN NAME Eliza J. Fields			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. RT. One Fallston Maryland 21047 Mr Lloyd Bloxham 2301 Harford Road		ADDRESS	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardio-vascular disease		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obstructive pulmonary disease - indeterminate		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 31 July 1964 to 9 September 1967 , that (I) was lost saw the deceased alive on 29 August 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE John W. Barnaby				23B. DATE SIGNED 9/11/67	
23C. PHYSICIAN'S NAME (Type) John W. Barnaby				23D. ADDRESS 1531 East North Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Henry Sander & Sons Inc.	
25C. FUNERAL DIRECTOR Baltimore Maryland		ADDRESS			

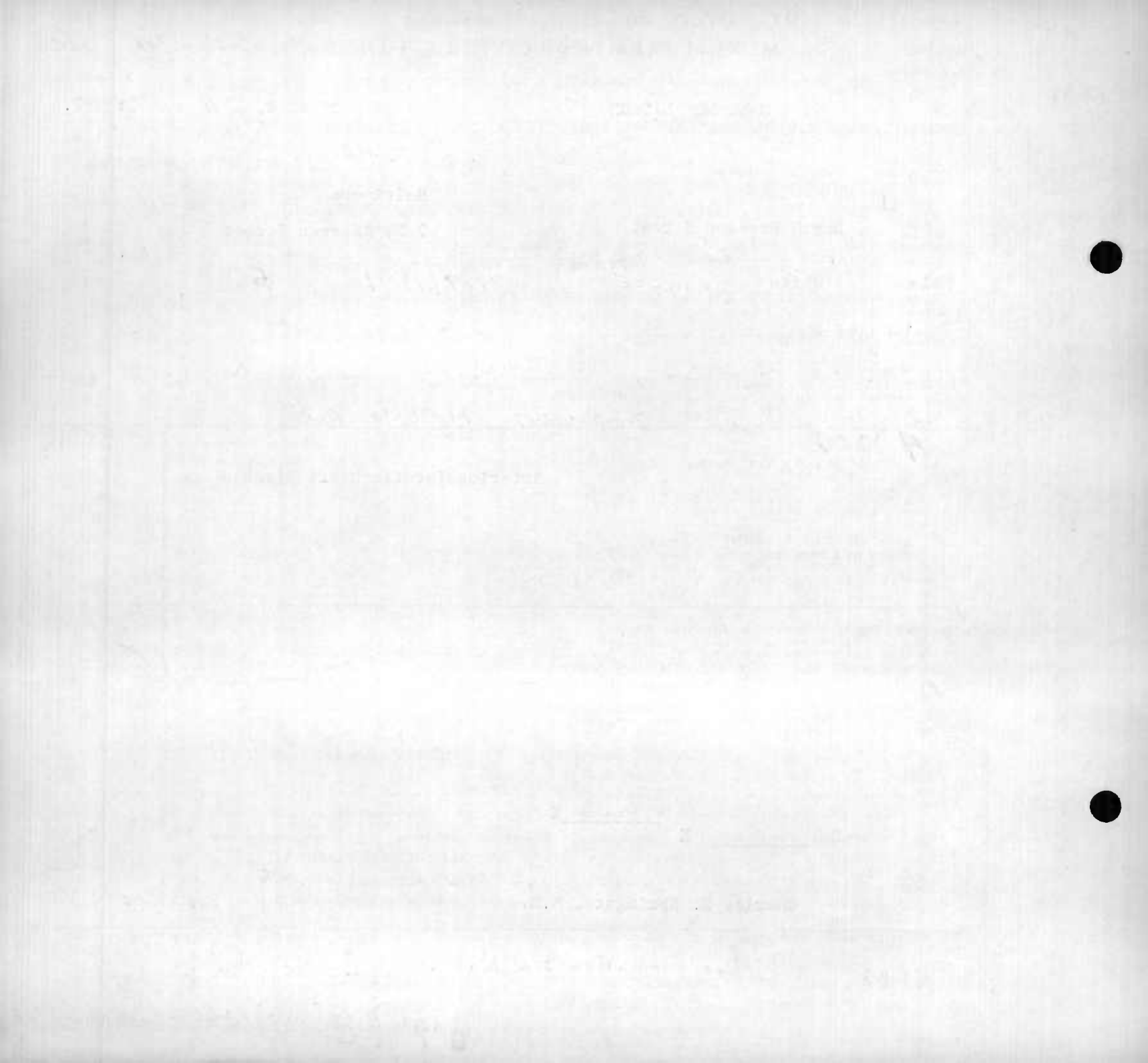
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Wiederholte Versuche - 2. Teil

2. Teil
2. Teil

Wiederholte Versuche

1		L-120 67 8728		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8728			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
GALTANO LAPACE			September 8, 1967 1:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
00 7 North Kresson Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-44		
D. STREET ADDRESS (If rural, give location) 7 N, Kresson Street					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	B. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
Male	White	SINGLE	9/29/1891	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED				Italy	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Antonino Lapace			U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Yes W.W.I.			213-09-4347		MR. Manfre-
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) Arteriosclerotic heart disease					
DUE TO					
(B) DUE TO					
(C) DUE TO					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				DATE SIGNED	
				September 8, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		9/12/67		Loudon PK. Nat'l.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
SEP 12 1967		Robert E. Taylor		Joseph N. Zaimos 263 S. Conkling St.	



B640

67 8729		BALTIMORE CITY HEALTH DEPARTMENT		67 8729	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		ALONZA BURRELL		2. DATE AND HOUR PRONOUNCED DEAD September 6, 1967 10:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY 9-01	
619 Parkwyrrh Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore	
D. STREET ADDRESS (If rural, give location)		619 Parkwyrrh Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH May 16, 1921	9. AGE (In years lost birthday) 46	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Inspector		Bethlehem Steel Corp.		Georgia	
13. FATHER'S NAME Emory H. Burrell		14. MOTHER'S MAIDEN NAME Eva Cordell		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hicks Funeral Hme. Elberton, Ga.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia DUE TO Carbon monoxide DUE TO Conflagration DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 619 Parkwyrrh Avenue 9-01	
21D. TIME OF INJURY (APPROX.) 9-6-67 8:59 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Found in burning apartment	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 7, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 9/10/67		23C. NAME of CEMETERY or CREMATORY Rockbranch Baptist Ch. Com.	
24A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR James M. Fields	
				ADDRESS Baltimore, Md.	

WILLEY FORD

WILLEY FORD

WILLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1551
RELEASED AS NOT A MEDICAL EXAMINER'S CASE BY DR. WIDSON. ASST. MEDICAL EXAMINER *Widson*

BIRTH NO. 67 8730										CITY HEALTH DEPARTMENT										BIRTH NO. 67 8730									
M.E. CASE NO.										CERTIFICATE OF DEATH										Registered No. 67 8730									
1. NAME OF DECEASED (Type or Print)										2. DATE AND HOUR OF DEATH																			
Calvin B. Hoffman Sr.										Sept 11, 1967										4 35 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)																			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										STATE B. COUNTY																			
Johns Hopkins Hospital										Maryland, Washington Co.																			
33										C. CITY OR TOWN (If outside city limits, write RURAL and give township)										71-00									
										D. STREET ADDRESS (If rural, give location)										Rd # 3.									
5. SEX										6. RACE										7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)									
Male										White										Married									
8. DATE OF BIRTH										9. AGE (In years last birthday)										10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)									
5-25-95										72										Retired Capt. & Guard									
11. BIRTHPLACE (State or foreign country)										12. CITIZEN OF WHAT COUNTRY?																			
Hagerstown, Md.										U.S.A.																			
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME																			
Lloyd Hoffman										Katherine Beard																			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS									
No										219-36-4931										Mr. Calvin B. Hoffman Jr. Hagerstown, Md.									
18. 540.1										CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										(A) Perforated gastric ulcer										10 1/2 hours									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										DUE TO																			
ANTECEDENT CAUSES										(B)																			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										DUE TO																			
(C)																													
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																													
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED										20A. AUTOPSY? (Yes or No)									
Sept 10, 1967										perforated gastric ulcer										YES									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)										21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.)										21E. INJURY OCCURRED										21F. HOW DID INJURY OCCUR?									
(Month) (Day) (Year) (Hour)										While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>																			
22. I certify that (I) (this hospital) attended the deceased from Sept 8, 1967 to Sept 11, 1967, that (I) (we) last saw the deceased alive on Sept 11, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																													
23A. SIGNATURE										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED									
Daniel Weiss																				Sept 11, 1967									
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS																			
DANIEL WEISS										Johns Hopkins Hospital																			
24A. BURIAL CREMATION, REMOVAL (Specify)										24B. DATE										24C. NAME OF CEMETERY OR CREMATORY									
Burial										9/13/67										Beaver Creek Cem.									
24D. LOCATION (City, town, or county) (State)																													
Washington Co., Md.																													
25A. DATE REC'D BY HEALTH DEPT.										25B. NAME OF REGISTRAR										25C. FUNERAL DIRECTOR ADDRESS									
SEP 12 1967										R. R. E. Jones										James M. Fields - Balto., Md.									

100-100000

Harold Hoffmann

Mr. White married 2-22-22

Rd. 3.

John Hoffman Hospital

Married

Charles B. Hoffmann Jr. Sept 11, 1912

Age 2

Refused to be seen

10-12 hours

Sept 10, 1912, beginning of the ulcer

12

10

Sept 11 1912

Sept 11 1912

10

Daniel Weiss
Daniel Weiss

John Hoffman Hospital

Sept 11, 1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-430				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8731	
BIRTH NO. 67 8731				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) MAUD ALICE ALLEN		2. DATE AND HOUR OF DEATH 9-10-67 at 11-00 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL 35				A. STATE MARYLAND B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 907, N. COLLINGTON AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED.		8. DATE OF BIRTH 3-4-1895	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES TRAVERS				14. MOTHER'S MAIDEN NAME MARY TRAVERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Charles B. McCormick	
				ADDRESS 3400 Cross Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH (A) Pen. Coronary Occlusion DUE TO (B) ASD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH four years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-8-67 to 9-10-67, that (I) (we) last saw the deceased alive on 9-10-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rodolfo M. Lim				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-10-67	
23C. PHYSICIAN'S NAME (Type) Rodolfo M. Lim				23D. ADDRESS C.H.H.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-14-67		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL Cem.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John A. Miller		25D. ADDRESS 2334 Jefferson St.	

1875

1876

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1878

1879

1880

1881

John C. Miller 1882

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8732
BIRTH NO. 67 8732		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>PRINCE JONES</i>		2. DATE AND HOUR OF DEATH <i>9-9-67</i> <i>4:40 P.M.</i>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home & Hospital</i>		A. STATE <i>MD</i> B. COUNTY		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
		D. STREET ADDRESS (If rural, give location) <i>301 23 S. Eden St.</i>		
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>Oct. 14, 1915</i>	9. AGE (In years last birthday) <i>52 yrs.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed; Debtor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>N. Carolina</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Harold Jones</i>		14. MOTHER'S MAIDEN NAME <i>Ida Crayton</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Willie Mae Scott</i>	
				ADDRESS
18. <i>759.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Pulmonary Insufficiency</i>		<i>?</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Res. Cystic Dec. of the lung</i>		<i>?</i>
		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumothorax</i>				
19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>9-9-67</i> 1967 to <i>9-9</i> 1967, that (I) (we) last saw the deceased alive on <i>9-9</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>R. M. Ginn</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-9-67</i>
23C. PHYSICIAN'S NAME (Type) <i>Rodolfo M. Lora</i>		23D. ADDRESS <i>CHH</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Sept 13/67</i>	24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cem</i>	24D. LOCATION (City, town, or county) (State) <i>A.A. County Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1967</i>	25B. NAME OF REGISTRAR <i>Dr. J. J. Johnson</i>	25C. FUNERAL DIRECTOR <i>Joseph T. Tolikow</i>	ADDRESS <i>1129 N. Carolina</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8733	
BIRTH NO. 67 8733		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sadie Emmick Myers		2. DATE AND HOUR OF DEATH 8-25-67 1:45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		A. STATE Maryland B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location) 4016 West Garrison Avenue Baltimore, Maryland 21215		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4016 West Garrison Avenue			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 7-28-1870	9. AGE (In years lost birthday) 97	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Alexander Marsh			14. MOTHER'S MAIDEN NAME Rachel Ann Osborn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-14-3505D	17. INFORMANT ADDRESS Mrs. Mary E. Bright same		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) A.S.C.V.D. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6 May 19 65 to August 19 67, that (I) (we) last saw the deceased alive on August 20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles H. Williams				23B. DATE SIGNED 8-25-67	
23C. PHYSICIAN'S NAME (Type) Charles H. Williams			23D. ADDRESS 1632 Reisterstown Rd. Pikesville, Md. 21208		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-28-67	24C. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	24D. LOCATION (City, town, or county) (State) Upperco Maryland		
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1967		25B. NAME OF REGISTRAR Frank D. Newell	25C. FUNERAL DIRECTOR ADDRESS Frank D. Newell		



FUNERAL DIRECTOR: IMPORTANT

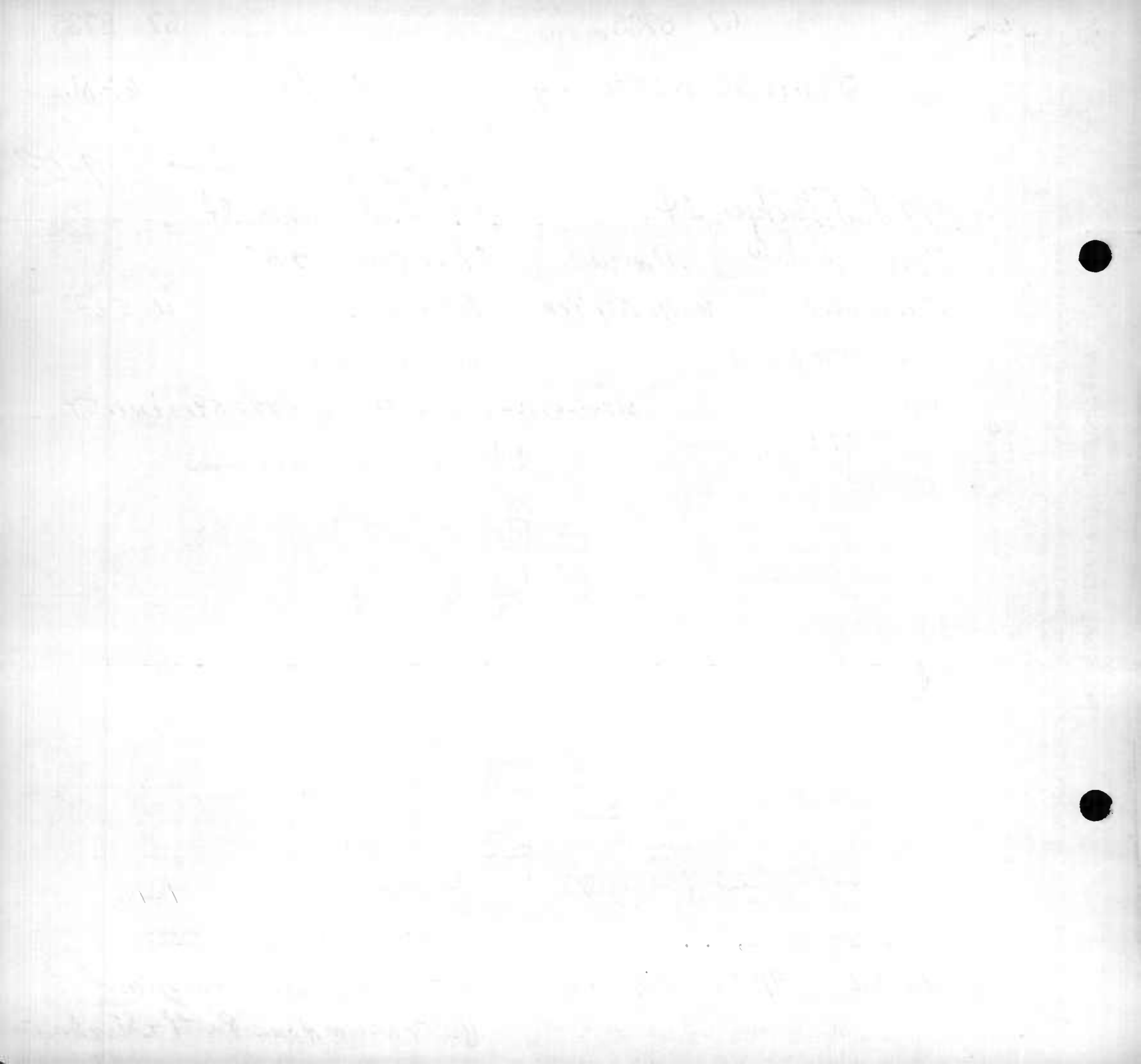
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8734		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8734	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) <i>Ralph B. Smith</i>		2. DATE AND HOUR OF DEATH <i>Sept 5, 1967 9⁰⁰ A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Maryland Gen. Hosp.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 53-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>4109 Wilford Mill Rd.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>Aug 27, 1906</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto. Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Major Motors</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
13. FATHER'S NAME <i>Murray C. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Brown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If Yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-03-7413</i>		17. INFORMANT <i>Medical Record</i>	
18. <i>163X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>PULMONARY EMBOLI</i> (A) DUE TO <i>CARCINOMA (SQUAM. CELL) OF LUNG, RESECTED</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>ARTERIO SCLEROSIS OF HEART, DISEASE, & OLD INFARCT</i>					
19A. DATE OF OPERATION <i>8/23/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Serious</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/16</i> 19 <i>7</i> to <i>9/5</i> 19 <i>7</i> , that (I) (we) last saw the deceased alive on <i>Sept 5</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Fredrick Cole Jr.</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9/5/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>FREDRICK COLE JR.</i>		23D. ADDRESS <i>314 Medical Arts Bldg.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sept. 8, 1967</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Knickerbocker Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Westminster, MD.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1967</i>		25B. NAME OF REGISTRAR <i>Ralph E. Taylor</i>		25C. FUNERAL DIRECTOR <i>David Taylor</i>	
				ADDRESS <i>5-11</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

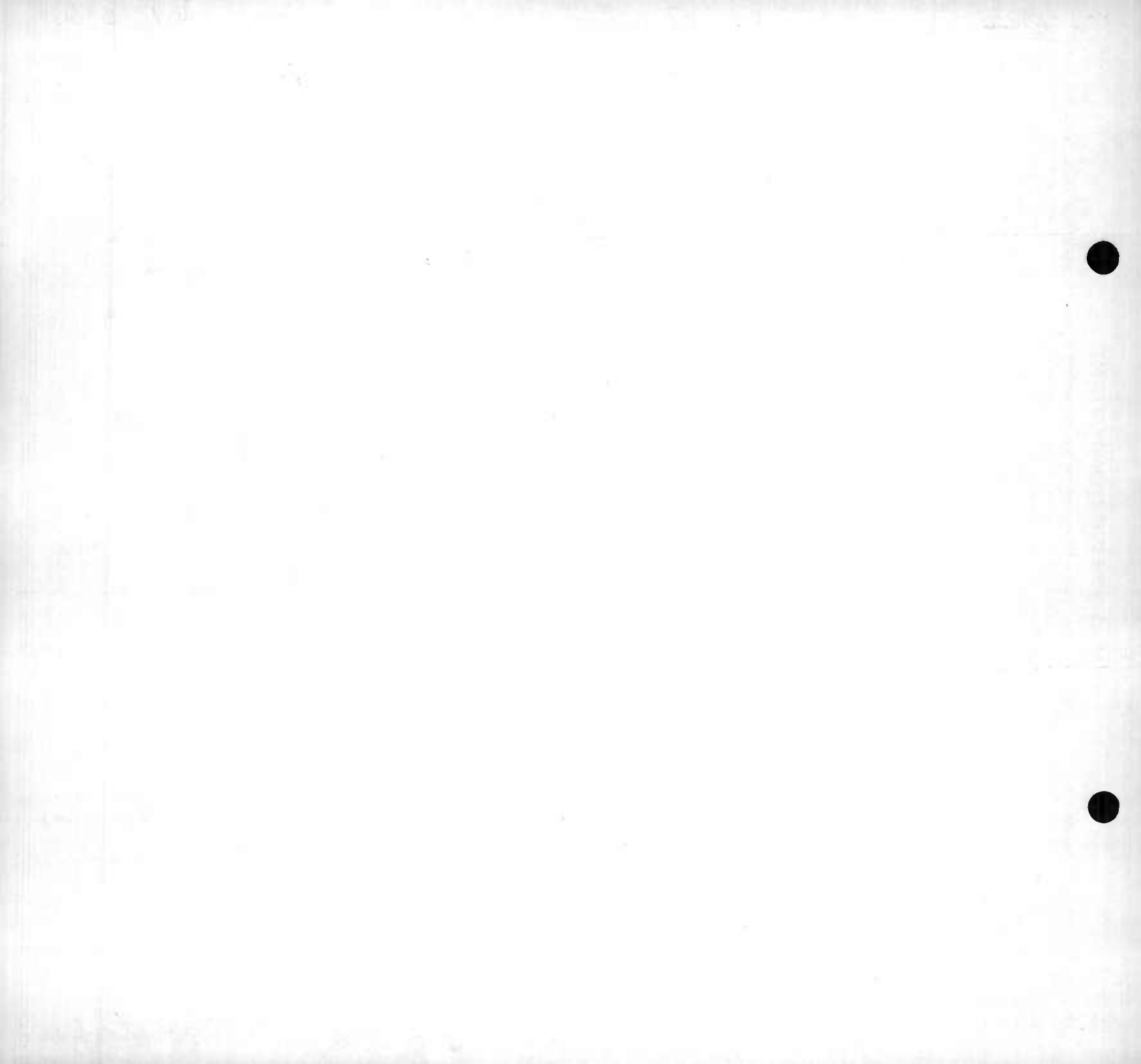
BIRTH NO. 67 8735		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8735	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>John J. Kettering</i>		2. DATE AND HOUR OF DEATH <i>9/11/67</i> <i>6 A.M.</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> <i>347 S. Stricker St.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>347 S. Stricker St.</i>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	
8. DATE OF BIRTH <i>2/4/92</i>		9. AGE (In years last birthday) <i>75</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-10-6872A</i>	
17. INFORMANT <i>Max Kettering</i>		ADDRESS <i>347 S. Stricker St.</i>		18. CAUSE OF DEATH <i>Pulmonary edema</i> <i>G.S. C.V.D.</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1967</i> to <i>Sept 11, 1967</i> , that (I) (we) last saw the deceased alive on <i>Sept 11, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stanley Ankudas</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9/11/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Stanley Ankudas, M.D.</i>		23D. ADDRESS <i>1101 Maiden Choice Lane # 21229</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/14/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Glen Haven Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1967</i>			
25B. NAME OF REGISTRAR <i>Walter Zangl</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Walter Zangl Home Pratt & Stricker St.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8736				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8736	
1. NAME OF DECEASED (Type or Print) Joseph F Spartzak				2. DATE AND HOUR OF DEATH Sept 10, 1967 11:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1728 Belt St				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 24-04 D. STREET ADDRESS (If rural, give location) 1728 Belt St			
5. SEX Male	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Mar 13, 1875	9. AGE (In years last birthday) 92	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNK			14. MOTHER'S MAIDEN NAME UNK				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>(A) DUE TO Myocardial Infarction (B) DUE TO Atherosclerotic Heart Disease (C)</p> </div> <div style="width: 10%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year</p> </div> </div>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/18 1966 to 9/10 1967, that (I) (we) last saw the deceased alive on 9/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John P. Urlock Jr				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/11/67	
23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR				23D. ADDRESS M.D. 1227 Washington Blvd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/13/67	24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem		24D. LOCATION (City, town, or county) Baltimore		(State) Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR G. G. E. Johnson		25C. FUNERAL DIRECTOR Mc Gully F. H.		ADDRESS 130 E Fort Ave 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8737</u>	
BIRTH NO. <u>67 8737</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) STOFFEL DORIS D.		2. DATE AND HOUR OF DEATH SEPTEMBER 11 1967 4:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Anne Arundel Co			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL CATON & WILKENS AVE BALTO 21229 MD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE D. STREET ADDRESS (If rural, give location) 740 N RITCHIE HWY			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 02/06/09	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) NEW YORK State	
13. FATHER'S NAME JUDSON DURAY		14. MOTHER'S MAIDEN NAME UNKNOWN Edwidge Bryan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO. 219-162310		17. INFORMANT ADDRESS ADMISSIONS SLIP--ST AGNES HOSPITAL	
18. 199-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic carcinoma of abdomen, frozen Pelvis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Metastatic carcinoma of abdomen, frozen Pelvis DUE TO (B) abdomen, frozen Pelvis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (IX) (this hospital) attended the deceased from SEPTEMBER 6 1967 to SEPTEMBER 11 1967 , that (X) (we) last saw the deceased alive on SEPT. 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above XX (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mohammad N. CHBAMET		23B. DATE SIGNED 09-11-67		23C. PHYSICIAN'S NAME (Type) M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Eugene B. Blumery		25D. ADDRESS Simpleton Funeral Home Glen Burnie, Md			

STREET 1100 1100

ST. JOHN'S HOSPITAL
1100 1100

ST. JOHN'S HOSPITAL
1100 1100

WHITE

MARRIED

NEW YORK

1100

NEW YORK

NEW YORK

U.S.A.

NEW YORK

NEW YORK

ST. JOHN'S HOSPITAL

1100

[Faint handwritten notes]

SEPTEMBER 11

SEPTEMBER 11

SEPTEMBER 11

09-11-57

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-140 BCH # 8738		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8738	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
49-86-82		Paul Abel		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		9/16/67 11 40 P.M.	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		Maryland		Anne Arundel Co.	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
		Glenburnie		52-00	
D. STREET ADDRESS		(If rural, give location)			
33 Mapledale Avenue		21061			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED, DIVORCED (specify) Married	7-20-1935	32	Engineer
108. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Westinghouse		Pennsylvania		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Paul L. Abel			Helen Drake		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No None			185-28-1710		
17. INFORMANT			ADDRESS		
Records: Baltimore City Hospitals			21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		2 days	
ANTECEDENT CAUSES		(B) DUE TO		? 3 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (1) (this hospital) attended the deceased from 9/16 1967 to 9/19 1967, that (1) (we) last saw the deceased alive on 9/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
S.W. Spaulding				9/19/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
S.W. Spaulding				M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	9/13/67	Fairview Cemetery	Wrightsville, Penna.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
SEP 13 1967	Robert E. Taylor	Eugene B. Fleming	Singleton Funeral Home Glen Burnie, Md.		

Paul Hill

1947

Respiratory failure
Metastatic Embolism
CA of @ Testis

No

W. Spangberg

1/1/47

1/1/47

1/1/47

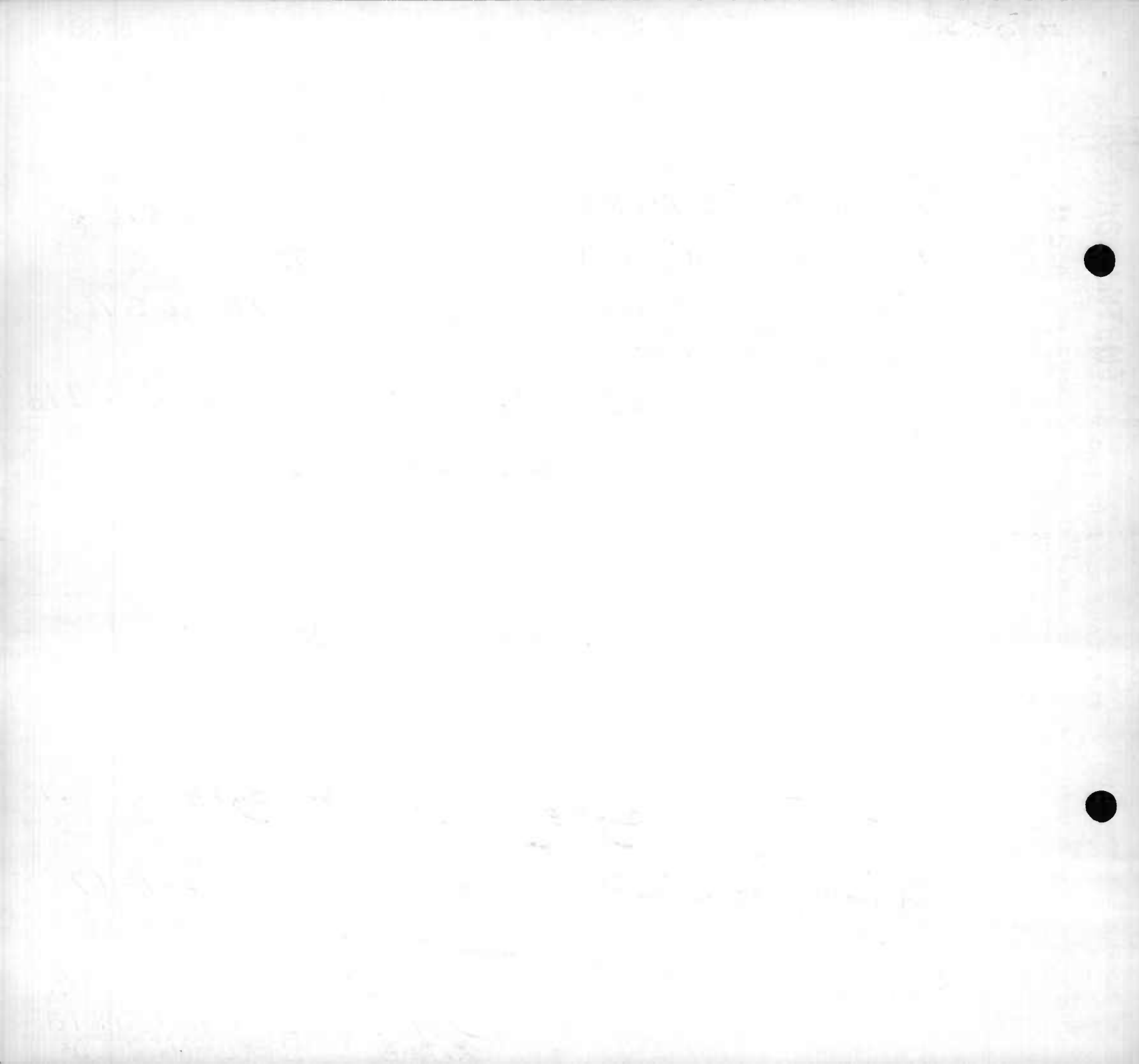
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Continued

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8739		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8739	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY WENDENBURG		2. DATE AND HOUR OF DEATH 9-9-67 7:23 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-01	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LONG GREEN NURSING HOME 115 W. MELROSE AVENUE		D. STREET ADDRESS (If rural, give location) 5926 GREENHILL AVENUE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-5-1869	9. AGE (In years last birthday) 97	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME FERDINAND SWANZIG		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. R1350-7214A		17. INFORMANT ELISIE THIRKEL 5926 GREENHILL RD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) INTERVENTIVE C. V. D.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of breast					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPS? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 to Sep 19 1967, that (I) (we) last saw the deceased alive on Sep 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Henry J. Haase MD		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-11-67	
23C. PHYSICIAN'S NAME (Type) DR. HENRY J. HAASE		23D. ADDRESS 2926 E. COHD SPRING LAKE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-12-67		24C. NAME of CEMETERY or CREMATORIUM PLEASANT GROVE	
24D. LOCATION (City, town, or county) (State) POWER RD. BORING MD.					
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR R. E. Egan		25C. FUNERAL DIRECTOR DIPPEL BROS. INC 7110 BELAIR RD. 81208 BALTO. MARYLAND	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8740		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8740	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Volenick Dr. Lee J.</i>			2. DATE AND HOUR OF DEATH <i>9-11-67 7:20 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hosp.</i>			A. STATE <i>Maryland.</i> 8. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21210 12-01</i>		
			D. STREET ADDRESS (If rural, give location) <i>220 Stoney Ford Rd. STONEYFORD</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed.</i>	8. DATE OF BIRTH <i>7-13-02</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
13. FATHER'S NAME <i>George Volenick</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>220-466955</i>		17. INFORMANT <i>William G. Volenick</i>
18. <i>434.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Congestive heart failure</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>months</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-11</i> 19 <i>67</i> to <i>9-11</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>7:15 PM 9-11</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Byung Kap Kang</i>				23B. DATE SIGNED <i>9-11-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>BYUNG KAP KANG</i>				23D. ADDRESS <i>Bon Secours Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-15-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1967</i>		25B. NAME OF REGISTRAR <i>R. E. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>ENSWORTH ARMACOST</i>	
				ADDRESS <i>4600 Liberty Heights</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8741	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 8741 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Rosa M. Paradiso				2. DATE AND HOUR OF DEATH September 9, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 4102 Oakford Avenue				A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4102 Oakford Avenue	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH April 23, 1900	9. AGE (In years last birthday) 67 Yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			11. BIRTHPLACE (State or foreign country) Sicily		12. CITIZEN OF WHAT COUNTRY? Sicily
13. FATHER'S NAME Antonio Maria			14. MOTHER'S MAIDEN NAME Alagna		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-05-0051		17. INFORMANT Washington, D. C. 20005 Riccardo Paradiso-1500 Massachusetts Ave.
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
CAUSE OF DEATH (A) DUE TO Myocardial Infarction (B) DUE TO Atherosclerotic Coronary Vascular Disease (C) _____ INTERVAL BETWEEN ONSET AND DEATH 2 minutes more than 4 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNOERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 9, 1967 to September 9, 1967 . that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antonio Galindo				23B. DATE SIGNED September 11, 67	
23C. PHYSICIAN'S NAME (Type) ANTONIO GALINDO				23D. ADDRESS 303 N. Rolling Rd Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 13 1967			
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hgts, Ave			

50

8442

1992

1
W-300

67 8742 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8742

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)~~MILTON~~ WITT, MILTON E. JR.

2. DATE AND HOUR PRONOUNCED DEAD

September 9, 1967 4:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Howard Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ellicott City

D. STREET ADDRESS (If rural, give location)

509 Wilton Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4/3/15

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

WESTINGHOUSE ELEC.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

MILTON E. WITT SR.

14. MOTHER'S MAIDEN NAME

ADA BRASHEARS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL
SECURITY NO.

215011621

17. INFORMANT

JULIA E. WITT

ADDRESS

18. E976X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of the head
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

509 Wilton Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9

9

67

?

21E. INJURY OCCURRED

WHILE AT
WORK

m.

NOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Subject shot himself

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/13/67

23C. NAME OF CEMETERY or CREMATORY

LORRAINE

23D. LOCATION

BALTO. CO. MD.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 13 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

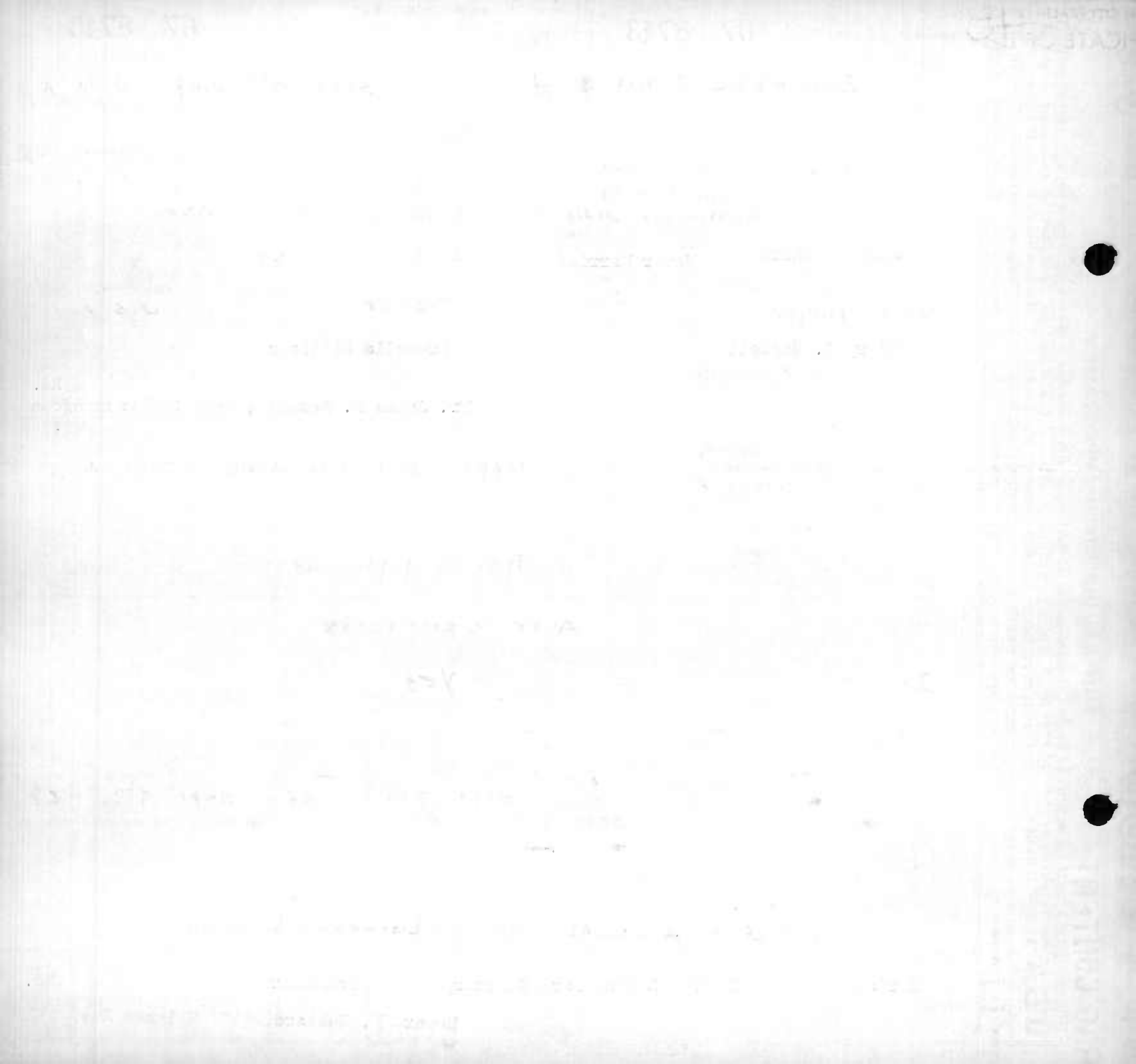
E. S. MACNABB

ADDRESS
301 FREDERICK RD
21228

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

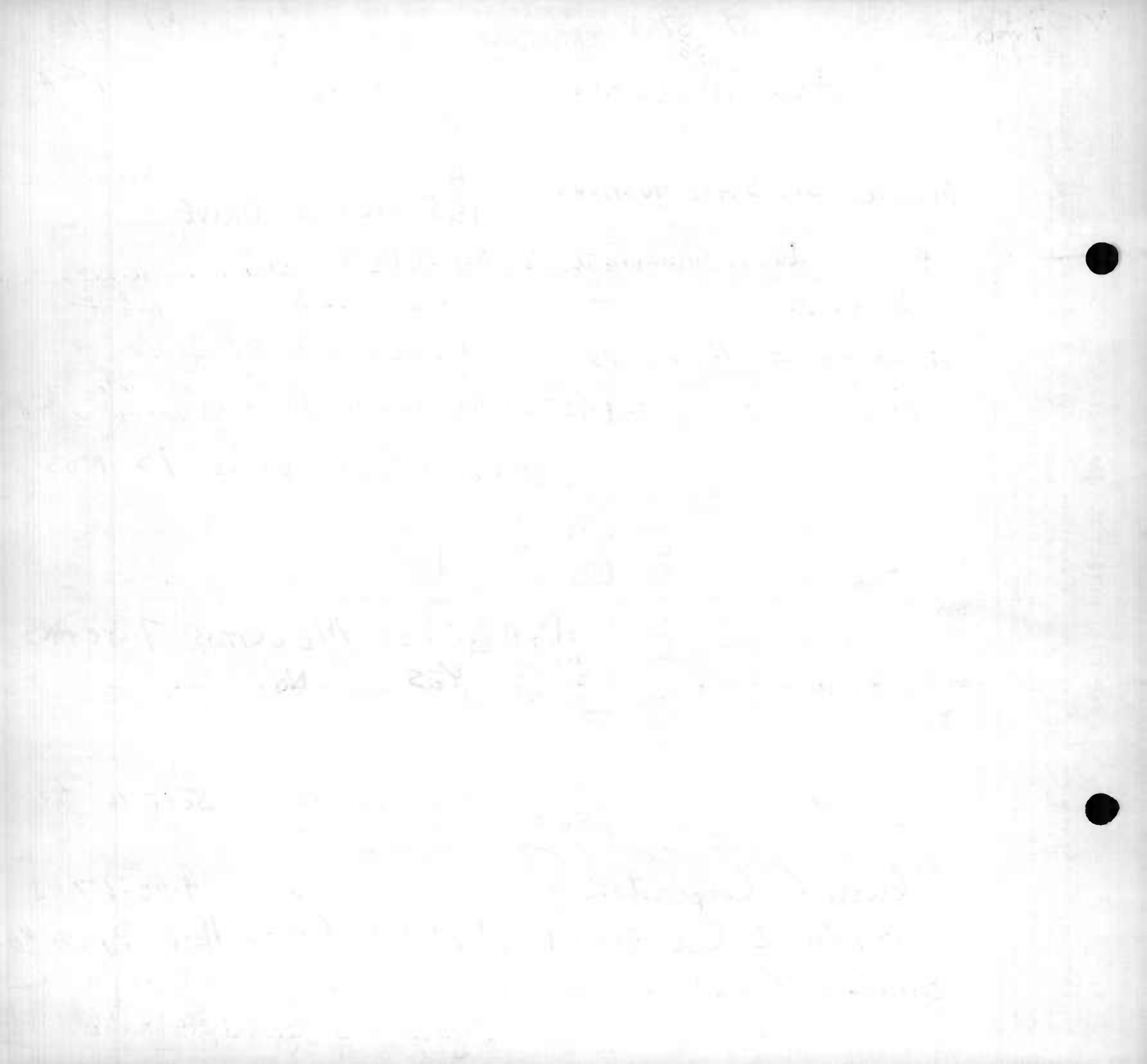
BALTIMORE CITY HEALTH DEPARTMENT									
67 8743 CERTIFICATE OF DEATH					Registered No. 67 8743				
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) BOSWELL JOHN B. H					2. DATE AND HOUR OF DEATH Sept 9th 1967 6-30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran hospital, 730, Ashburton St. Baltimore 21216.					A. STATE MD				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-47				
					D. STREET ADDRESS (If rural, give location) 3025, Windsor Ave.				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 6-30-91	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed.		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry D. Boswell				14. MOTHER'S MAIDEN NAME Drucella Williams					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. James M. Boswell, 6418 Old Washington Rd.			ADDRESS		
18. 5-4001 CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) Upper G.I. Bleeding			INTERVAL BETWEEN ONSET AND DEATH Two days.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) Possibly peptic ulcer.				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -					
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -					
22. I certify that (this hospital) attended the deceased from Sept 7th 1967 to Sept 9th 1967 , that (I) last saw the deceased alive on Sept 9th 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE Dr. Bipin A. Desai					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DR. BIPIN A. DESAI.					23D. ADDRESS Lutheran hospital.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) Baltimore		24E. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8744					67 8744				
BIRTH NO.					REGISTERED NO.				
M.E. CASE NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) ANNA MULLIKIN					9-10-67 1:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL					A. STATE MD. B. COUNTY 9.9.C.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS				
					D. STREET ADDRESS (If rural, give location) 155 ACTON DRIVE				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH MAR 31, 1898	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WILLIAM E. HIGGINS					14. MOTHER'S MAIDEN NAME MARGARET MCQUAY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214-22-7208		17. INFORMANT Mrs. Anna H. Kellenberg, 155 Acton Dr. Annapolis, Md.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 332X14260X					CAUSE OF DEATH (A) Cerebral thrombosis DUE TO			INTERVAL BETWEEN ONSET AND DEATH 15 MOS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS 7 YEARS									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from JULY 21, 1966 to SEPT. 10, 1967 , that (X) (we) lost saw the deceased alive on SEPT. 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Irving L. Cooperstein M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-10-67		
23C. PHYSICIAN'S NAME (Type) IRVING L. COOPERSTEIN M.D.					23D. ADDRESS Montebello State Hosp. BALTO. MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME OF CEMETERY or CREMATORY Bozman Cemetery		24D. LOCATION (City, town, or county) (State) Bozman, Maryland			
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Danison E. Leonard		ADDRESS St. Michaels, Md		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8745	
BIRTH NO. 67 8745		67 8745 CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HAHN, CHARLES A.		2. DATE AND HOUR OF DEATH SEPTEMBER 11, 1967 10:15A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 53-00 D. STREET ADDRESS (If rural, give location) 608 COLERAINE RD. 21229			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED MARRIED	8. DATE OF BIRTH 11-10-93	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES HAHN		14. MOTHER'S MAIDEN NAME LEAH (HAHN) OUE/MAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR I		16. SOCIAL SECURITY NO. 213-05-97465		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiogenic shock - DUE TO (B) Acute myocardial infarction DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 11, 1967 to SEPTEMBER 11, 1967 , that (I) (we) lost saw the deceased olive on SEPTEMBER 11, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE XXXXXX <i>P. Dibos</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/11/67	
23C. PHYSICIAN'S NAME (Type) P. DIBOS		23D. ADDRESS ST. AGNES HOSP; CATON & WILKENS AVES. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/11/67		24C. NAME OF CEMETERY or CREMATORY LODOWAN PARK CEMETERY	
24D. LOCATION (City, town, or county) (State) FREDERICK RD		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR <i>P. Dibos</i>	
25C. FUNERAL DIRECTOR WEBER FUNERAL HOME		ADDRESS 5311 EDWARDS AVE			

12:15A
A. J. JAMES
12:15A

17. VANCE HOSPITAL
200 COLLEGE STREET
17. VANCE HOSPITAL

DATE: 11-11-55
TIME: 11:15 A.M.
PATIENT: JAMES, A. J.
ST. VANCE HOSPITAL
17. VANCE HOSPITAL

RECEIVED IN
RECEIVED IN

RECEIVED IN
RECEIVED IN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8746	
BIRTH NO. 67 8746		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 9/11/67 11:35 P.M.	
1. NAME OF DECEASED (Type or Print) Mr. Charles J. Jones			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE md. B. COUNTY -	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSP. Baltimore, md. 21202		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2-03	
		D. STREET ADDRESS (If rural, give location) 1611 Shakespeare St.	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	B. DATE OF BIRTH 1/30/20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ORDER FILLER		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 47
13. FATHER'S NAME Shannon Jones		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME margaret Robinson		17. INFORMANT Hosp. chart	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. 220-10-9252	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ca. Larynx		CAUSE OF DEATH Carcinomatosis	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 9/11/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Larynx	
19C. DATE OF OPERATION 9/11/67		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. HOW DID INJURY OCCUR?	
21F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/7/67 to 9/11/67 and that (I) (we) last saw the deceased alive on 9/11/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David S. McHold		23B. DATE SIGNED 9/11/67	
23C. PHYSICIAN'S NAME (Type) David Stanley McHold		23D. ADDRESS 1101 St. Paul St., Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9/13/67	24C. NAME of CEMETERY or CREMATORY MEDON RIDGE CEMETERY	24D. LOCATION (City, town, or county) (State) WASHINGTON BLVD
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967	25B. NAME OF REGISTRAR John W. McKerns	25C. FUNERAL DIRECTOR JOHN W. MCKERNSONS INC.	ADDRESS 401 S. CHESTER ST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8747</u>	
BIRTH NO. <u>67 8747</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NETTIE PICKETT		2. DATE AND HOUR OF DEATH 9-8-67 3:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY B C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 13 8-02 D. STREET ADDRESS (If rural, give location) 2415 E. LAFAYETTE ST. AVE.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, MARRIED (Specify)	8. DATE OF BIRTH 6-28-16	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM WASHINGTON			14. MOTHER'S MAIDEN NAME FRONIE HENRY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 228-03-3161		17. INFORMANT EMMET PICKETT 2415 E. LAFAYETTE AVE	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Cancer of breast DUE TO (B) DUE TO (C) 		INTERVAL BETWEEN ONSET AND DEATH 10 mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Metastasis of cancer to lung					
19A. DATE OF OPERATION 9		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/8 12:30 AM 19 67 to 9/8 3:20 AM 19 67 , that (I) (we) last saw the deceased alive on 9/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas C. Butler M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9/8/67	
23C. PHYSICIAN'S NAME (Type) THOMAS C. BUTLER			23D. ADDRESS M.D. 601 N. Broadway		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-12-67		24C. NAME OF CEMETERY OR CREMATORY MT Calvary	
24D. LOCATION (City, town, or county) (State) a. a. County Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967			
25B. NAME OF REGISTRAR Joseph E. Feltner		25C. FUNERAL DIRECTOR JOSEPH KNIGHT 1639 N. BROADWAY			

Cancer of breast

Metastases of cancer to lung

1918 15th Nov 1918

1918

101 N Broadway

1918

Thomas C. Butler
THOMAS C. BUTLER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8748		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8748	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print)			CLARE BROWN		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			2. DATE AND HOUR OF DEATH		
FULL NAME OF HOSPITAL OR INSTITUTION			9-12-67 7:40 AM M.		
(If not in hospital or institution, give street address or location)			A. STATE MARYLAND		
THE JOHNS HOPKINS HOSPITAL			B. COUNTY		
5. SEX FEMALE			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
6. RACE NEGRO			BALTIMORE		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			D. STREET ADDRESS (If rural, give location)		
8. DATE OF BIRTH 12-15-01			244 DOUGLAS COURT		
9. AGE (In years last birthday) 65			11. BIRTHPLACE (State or foreign country)		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			12. CITIZEN OF WHAT COUNTRY? USA		
10A. USUAL KIND OF BUSINESS OR INDUSTRY			14. MOTHER'S MAIDEN NAME		
13. FATHER'S NAME GEORGE AMES			MARY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
18. CAUSE OF DEATH			Interval BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			3 wks		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			4 wks		
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. HOW DID INJURY OCCUR?		
21E. INJURY OCCURRED					
21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 8/14 1967 to 9/12 1967, that (1) (we) last saw the deceased alive on 9/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Thomas C. Butler			9/12/67		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
THOMAS C. BUTLER			601 N. BROADWAY, BALTO MD		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			9-16-67		
24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Mt Auburn Cmt			Balto MD		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
SEP 13 1967			P. E. E. F. F. F.		
25C. FUNERAL DIRECTOR			ADDRESS		
Chapman Wilson			1001 B. B. B.		

GI Hemorrhage
Subcutaneous bleed

THOMAS C. BUTLER
THOMAS C. BUTLER

601 W. BROADWAY, BALDWIN
9/12/10
8/11/10
9/11/10
9/11/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8749	
BIRTH NO. 67 8749		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Agnes McKell		2. DATE AND HOUR OF DEATH Sept. 12, 1967 105 ^{M.}	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY	
90 1105 E. Fayette Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1802 E. Chase Street			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12-25-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Rich		14. MOTHER'S MAIDEN NAME Emma Jane Jackson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Emory J. Rich ADDRESS Box 397 Severna Pk.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CHF HERD		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 d. 1 yr	
19. DATE OF OPERATION 8-15-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (L) Simple Mastectomy		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (XXXXXX) attended the deceased from Mar. 19, 1966 to 12 Sept. 1967 , that (I) (X) last saw the deceased alive on 12 Sept. 1967 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did) view the body after death.					
23A. SIGNATURE J. Hulla		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 12, 1967	
23C. PHYSICIAN'S NAME (Type) J. Hulla		23D. ADDRESS 2214 E. Fayette Street 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/67		24C. NAME OF CEMETERY or CREMATORY Int. Auburn	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR William J. Chatman		ADDRESS 1701 M. E. Cull ST.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8750		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8750	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elizabeth Meredith		2. DATE AND HOUR OF DEATH 9/11/67 8:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GEN'L HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 411 S. CHESTER ST - 21220		11. BIRTHPLACE (State or foreign country) MARYLAND	
5. SEX F	6. RACE Can	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 02/07/82	9. AGE (In years last birthday) 85	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNK WOWN Adam Schoff		14. MOTHER'S MAIDEN NAME Rose Elsasser K WOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-01-9892		17. INFORMANT Mrs. Rose M. Badart		ADDRESS 5519 Old Lawyers Hill	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Pneumonia -		INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Fracture - R hip		3 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardio Vasc disease		(C)			
19A. DATE OF OPERATION 8/26/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex - R hip		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO?		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) BOLTON HILL NURSING HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) BOLTON HILL NURSING HOME	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 22 67		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR? ASSUMED PT FELL	
22. I certify that (this hospital) attended the deceased from 08-22-67 19 to 9/11/67 19 that (we) last saw the deceased alive on 9/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert M. Brazley		M.D. Attending Phys. Med. Director Staff Phys. X		23B. DATE SIGNED 9/11/67	
23C. PHYSICIAN'S NAME (Type) ROBT. M. BEAZLEY		23D. ADDRESS MARYLAND GEN'L HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-1967		24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		25D. ADDRESS 1901-07 Eastern Ave.			

John Doe
Jane Smith

100-100000-100000

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LONIE (Lonnie)

SMITH

2. DATE AND HOUR PRONOUNCED DEAD

September 10, 1967 11:10 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2717 Lauretta Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2717 Lauretta Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Wid.

8. DATE OF BIRTH

2/16/1901

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

N/A.

11. BIRTHPLACE (State or foreign country)

Ansonville, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

242-10-1813

17. INFORMANT

ADDRESS

House Connady 2833 Harlem

18. 1557 / I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of Gall Bladder with

~~Metastases~~

Metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

9/10/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9-16-67

23C. NAME of CEMETERY or CREMATORY

MT. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 13 1967

24B. NAME OF REGISTRAR

R. L. E. F. F. F.

24C. FUNERAL DIRECTOR

Morton & Dyett

ADDRESS

1701 LAUREN ST.

UNITED STATES
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Memorandum
TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [illegible]

W. A.
W. A.

W. A. [illegible]

W. A. [illegible]

[Signature]

W. A. [illegible]

W. A. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8752		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8752	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Nora Haynes		2. DATE AND HOUR OF DEATH 9/9/67 11:00AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY District of Columbia		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp of Baltimore Inc.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Washington		D. STREET ADDRESS (If rural, give location) 4304 penhuxst Ave #15 (911 Evars ST., N.E.)	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Mar widow	8. DATE OF BIRTH 8/7/92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) Warrington, N.C.	
13. FATHER'S NAME Henry Boone		14. MOTHER'S MARRIED NAME Ella Boone		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-644306		17. INFORMANT Mrs. Nancy Alston ADDRESS Wash. D.C. 911 Evars St. N.E.	
18. 204.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Renal shutdown DUE TO (B) Hepato renal syndrome DUE TO (C) Chronic myelocytic leukemia		INTERVAL BETWEEN ONSET AND DEATH 72 hours 5 days 1 1/2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/5 19 67 to 9/9 19 67 , that (I) (we) lost saw the deceased alive on 9/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Martin S. Liberman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) Martin S. Liberman		23D. ADDRESS Sinai Hosp. of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-67		24C. NAME OF CEMETERY or CREMATORY Lincoln Mem. Cem.	
24D. LOCATION (City, town, or county) (State) Washington D.C.		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR MORFON, E. Dgett FH.			
ADDRESS 1701 LAURENS ST.					

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Washington DC

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Edward Bruce

Washington DC
Ellie Boone

Government of Maryland

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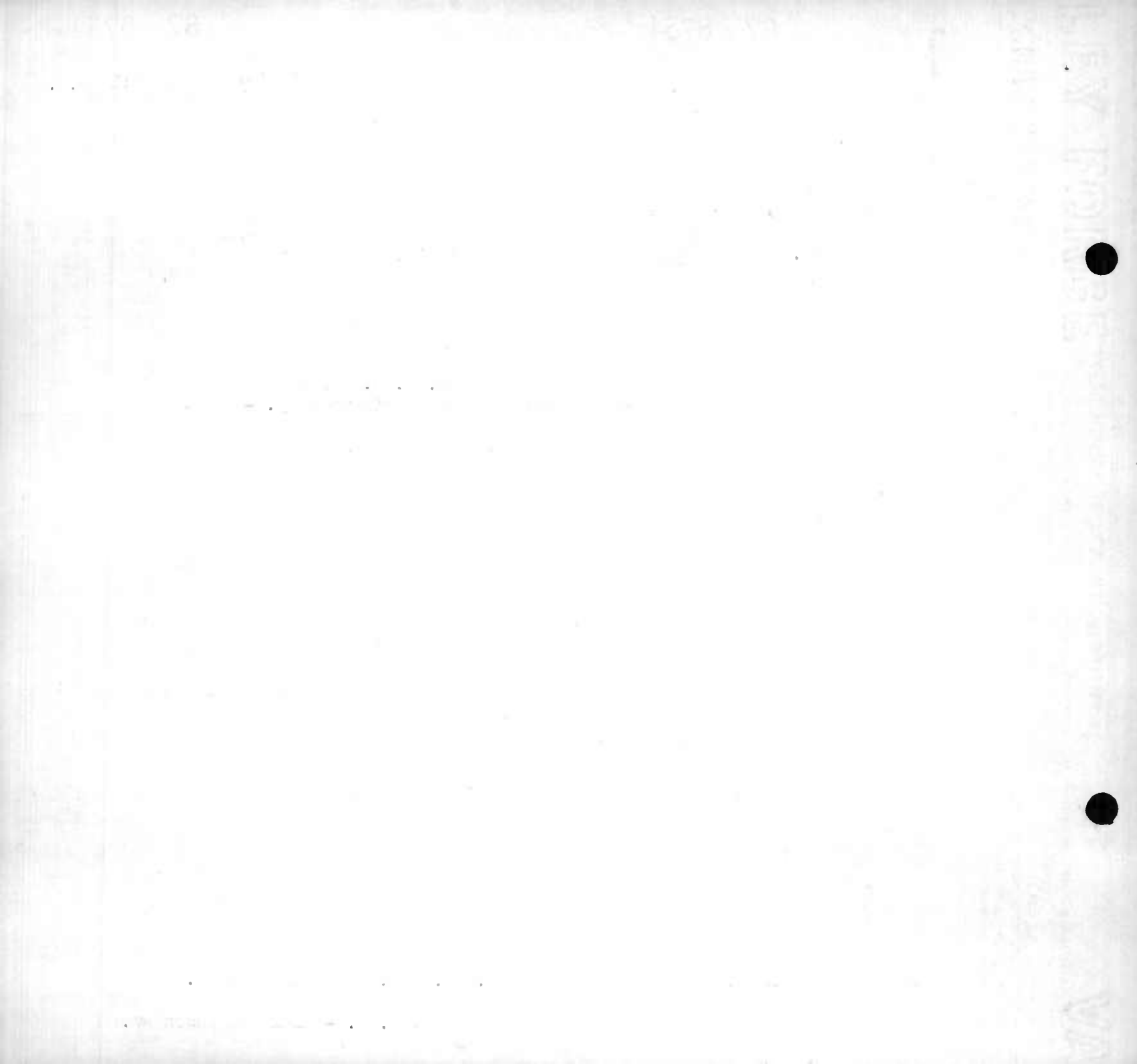
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8753</u>	
BIRTH NO. <u>67 8753</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		NAME OF DECEASED (Type or Print) <u>Mary Sohl</u>		2. DATE AND HOUR OF DEATH <u>Sept 12, 1967</u> <u>6:30 A.M.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Little Sisters of the Poor</u> <u>1200 Valley St.,</u> <u>Baltimore, Md. 21202</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>10-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1200 Valley St.,</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify)	8. DATE OF BIRTH <u>apr. 27, 1887</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>John Kaufman</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Minick</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or at unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-3768 D</u>	17. INFORMANT <u>Little Sisters of the Poor</u> ADDRESS		
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Massive myocardial infarct</u> DUE TO (B) <u>Diabetes mellitus</u> DUE TO (C) <u>A-S.C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>Sept 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 12, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Ankudas</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Stanley Ankudas</u>				23D. ADDRESS M.D. <u>1101 Maiden Choice Lane Balt. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/14/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Philip Herwig Sons Orleans St</u> ADDRESS <u>2024</u>			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

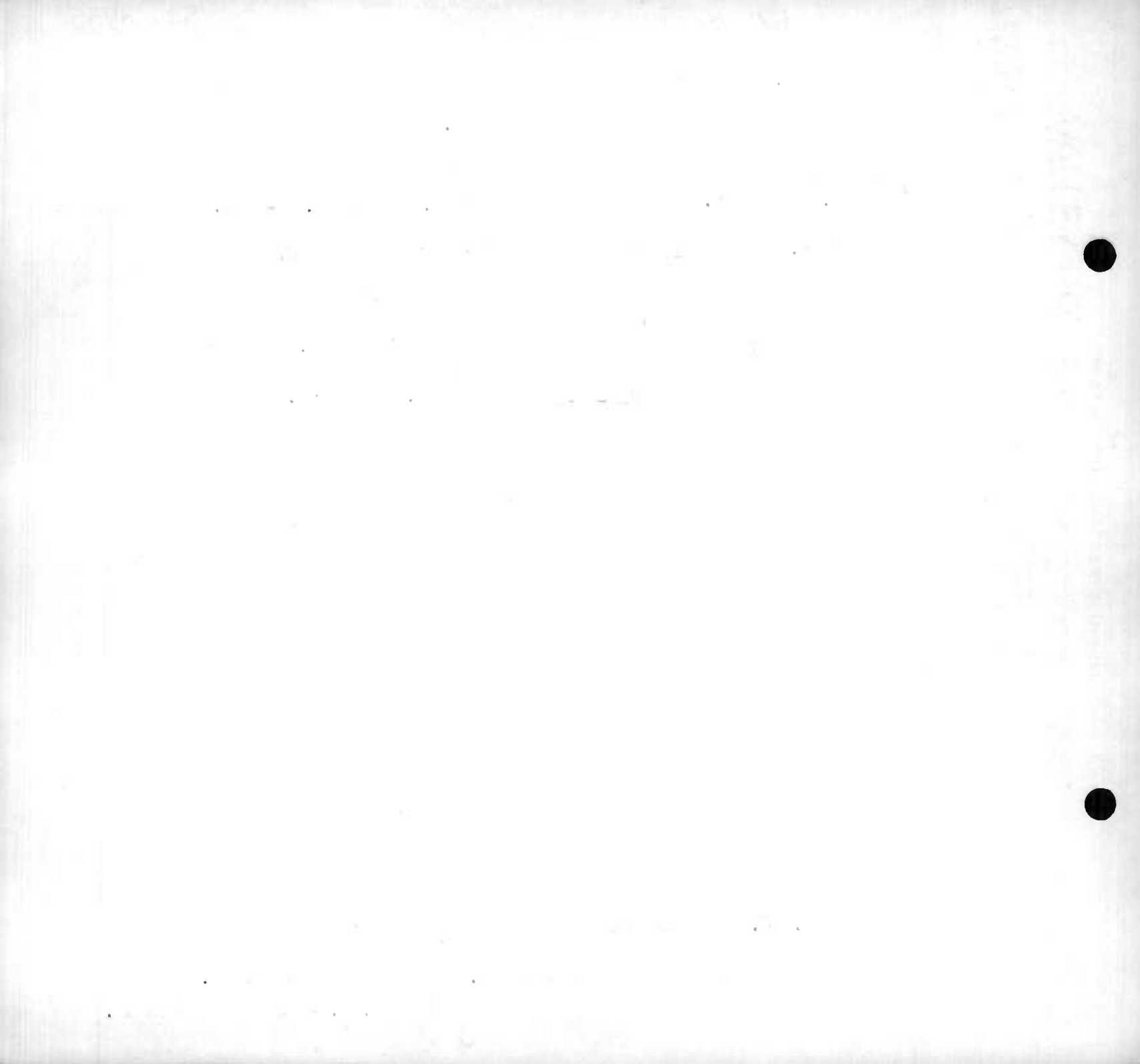
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8754	
BIRTH NO. 67 8754		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. BERTHA M. LAMP		2. DATE AND HOUR OF DEATH 9/11/67 1:15 A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL 100 N. BROADWAY, BALTIMORE, MD. 21231		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 4609 MANORDENE ROAD B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND 21229 D. STREET ADDRESS (If rural, give location)			
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11/19/1901 92	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME CHRISTIS GARMAN		
14. MOTHER'S MAIDEN NAME NOLA KING			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 216 32 9485			17. INFORMANT Mrs. E. H. Reibetanz 3109 Northern Pkwy. - 21214		
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) Cerebrovascular Accident (B) Due to (C) Interval Between Onset and Death Hours					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulm. Emphysema			Years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-26-1967 to 9-11-1967 , that (I) (we) last saw the deceased alive on 9-11-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodelio M. L. M. M.D.				23B. DATE SIGNED 9-11-67	
23C. PHYSICIAN'S NAME (Type) Rodelio M. L. M. M.D.				23D. ADDRESS CHH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Pk. Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR R. E. Reibetanz		25C. FUNERAL DIRECTOR Witzke E. D.	
ADDRESS 4101 Edmondson Av.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

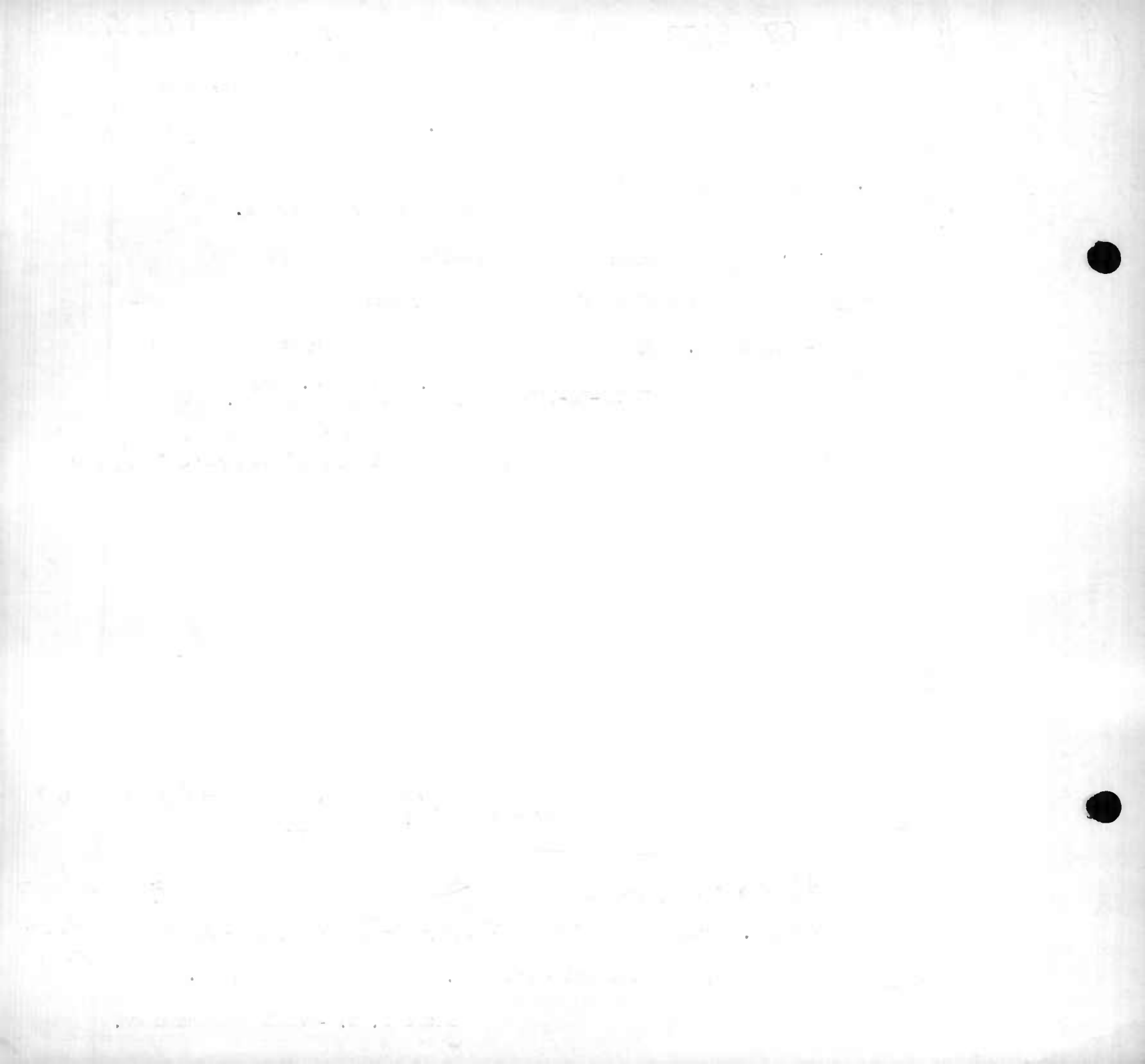
BIRTH NO. 67 8755		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8755	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Annie E. Wedemeyer		2. DATE AND HOUR OF DEATH September 11, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 28-04		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 90 General German Aged Home 22 S. Athol Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 22 S. Athol Av. - Gen. German Aged Home			
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 11/17/79	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anton Widemeyer			14. MOTHER'S MAIDEN NAME Catherine R. Steinbach		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-0898A		17. INFORMANT General German Aged Home 22 S. Athol Ave.	
18. 422.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Cardiac Failure		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic myocardial degeneration.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 11, 1967 to 11 Sept 1967 , that (I) (we) last saw the deceased alive on 11 Sept 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Bryson				23B. DATE SIGNED 12 Sept 67	
23C. PHYSICIAN'S NAME (Type) Wm. J. Bryson		23D. ADDRESS 4605 Edmondson Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR Witzke P. D.		25C. FUNERAL DIRECTOR 4101 Edmondson Av.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8756	
BIRTH NO. 67 8756		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William J. Eney		2. DATE AND HOUR OF DEATH September 10, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8. COUNTY Balto Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville D. STREET ADDRESS (If rural, give location) 1918 Old Frederick Rd. #28			
5. SEX M	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/17/28	9. AGE (In years last birthday) 39	10. Under 1 Yr. Months 1 Yr. Days 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Dorn Transfer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Late - William E. Eney			14. MOTHER'S MAIDEN NAME Margaret Swayne		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 215-24-7528		17. INFORMANT Mrs. William J. Eney 1918 Old Frederick Rd. 21226	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Coronary Thrombosis 2 hrs DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/10 19 67 to 9/10 19 67 , that (I) (we) last saw the deceased alive on 9/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Pound				23B. DATE SIGNED 9/12/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John C. Pound		3325 Frederick Ave Balto 29			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	9/14/67	New Cathedral Cem.	Baltimore, Md. Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
SEP 13 1967	Robert E. Johnson	Witke E. D.	- 4101 Edmondson Av.		



H-200

67 8757 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8757

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)ALBERT *FRANKLIN* HUSS

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1967 12:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

120 S. Calhoun St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

July 3, 1889

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HUCKSTER

10B. KIND OF BUSINESS OR INDUSTRY

PRODUCE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES A. HUSS

14. MOTHER'S MAIDEN NAME

Christina Heinrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL
SECURITY NO.

218-22-4788

17. INFORMANT

ADDRESS

Elizabeth Walters 1205 Calhoun St.

18. *E812.1*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Cranio Cerebral Injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Pratt St. West of Carey St. 19-03

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9/12/67 12:10 P. M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck

by truck

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-15-67

23C. NAME of CEMETERY or CREMATORY

Western

23D. LOCATION (City, town, or county)

BALTIMORE

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

650 L. Schwab Funeral Home
Francis H. Miller 2101 Hindwicks Ave.

VALLEY TAPER

VALLEY FORD

VALLEY FORD

17-10-19

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17-10-19

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 8758		CERTIFICATE OF DEATH		Registered No. 67 8758	
1. NAME OF DECEASED (Type or Print) ARMSTRONG, John Wesley						2. DATE AND HOUR OF DEATH 9-12-67 1:40 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4903 St GEORGES AVENUE			
5. SEX MALE		6. RACE NEGROID		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-21-06		9. AGE (In years lost birthday) 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD DUTY				10B. KIND OF BUSINESS OR INDUSTRY GENR'L SVC ADMIN		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ROBERT ARMSTRONG						14. MOTHER'S MAIDEN NAME CATHERINE CURTIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 11-18-42 TO 8-18-43				16. SOCIAL SECURITY NO. 218-03-4213		17. INFORMANT VA HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218			
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemo, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) Carcinoma of the lung, epidermoid, well-differentiated, with metastases (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH greater than 7 months	
19A. DATE OF OPERATION 9		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 SEPTEMBER 1967 to 12 SEPTEMBER 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 SEPTEMBER 1967 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
23A. SIGNATURE George W Gaffney M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED September 12, 1967			
23C. PHYSICIAN'S NAME (Type) George W Gaffney M.D.						23D. ADDRESS 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-18-67		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Robert Williams		ADDRESS 1701-23 N Bond St			

A. 1000

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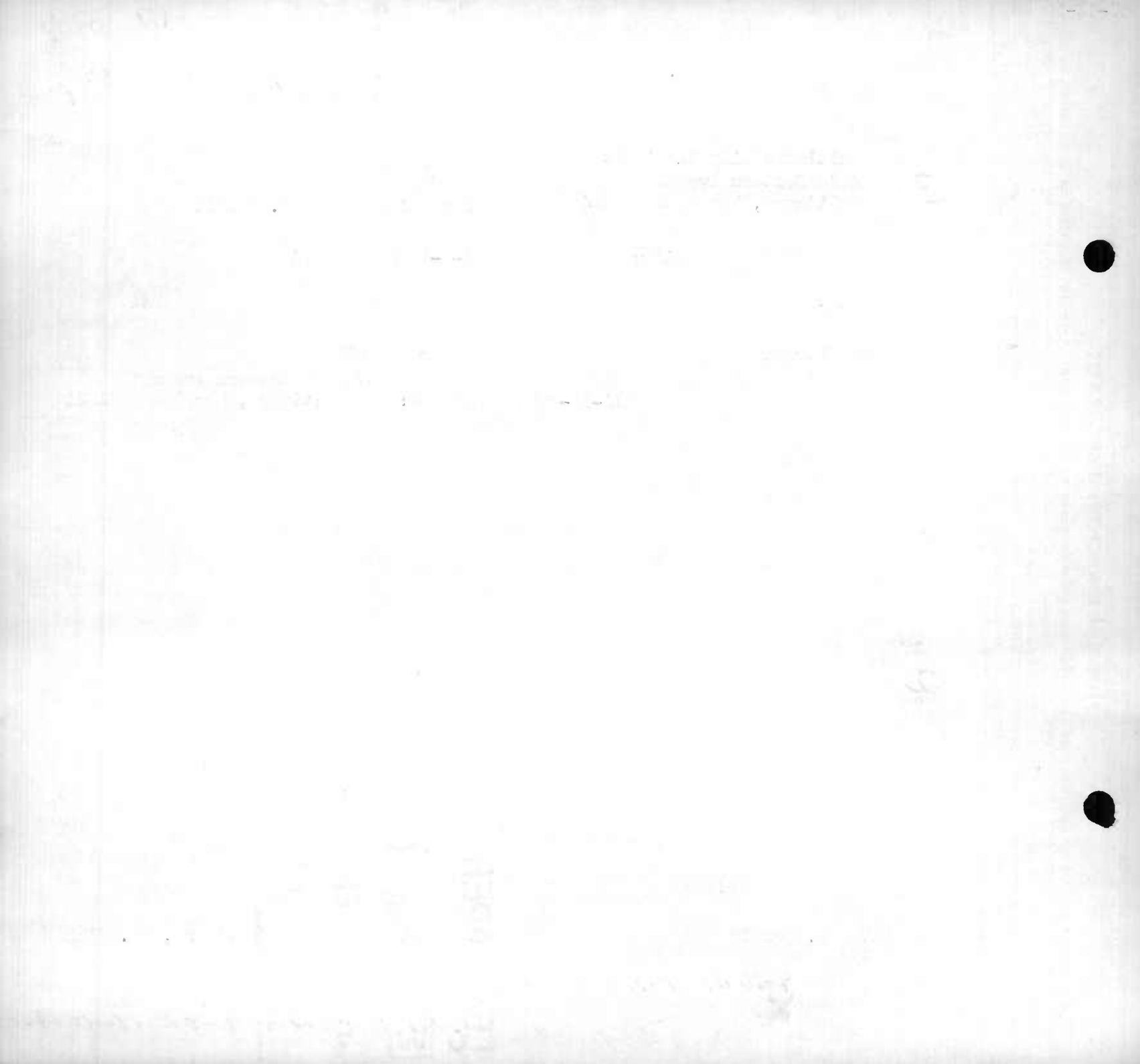
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452		67 8759		Baltimore City Health Department		Registered No. 67 8759	
CERTIFICATE OF DEATH							
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BLANCHE M. WILLIAMS		9/11/67 7 30 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2913 Winchester St. #21216			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 4-2-1873	9. AGE (In years last birthday) 94	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edmund Morgan				14. MOTHER'S MAIDEN NAME Mary Sewell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-56-7512		17. INFORMANT ADDRESS BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 434114-151X				CAUSE OF DEATH (A) acute pulmonary Edema DUE TO (B) Congestive Heart Failure DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 hrs Then	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. adenocarcinoma of the stomach							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9/9 to 9/11 1967, that (1) (we) last saw the deceased alive on 9/11/67 19 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David E Mc Beth M.D.						23B. DATE SIGNED 9/11/67	
23C. PHYSICIAN'S NAME (Type) DAVID E. McBETH				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE REC'D BY HEALTH		25B. NAME OF REGISTRAR SEP 13 1967		25C. FUNERAL DIRECTOR Wm. G. March		25D. ADDRESS 928 E. North Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 8760		CERTIFICATE OF DEATH				Registered No. 67 8760			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mr WILLIAM BOOKER				2. DATE AND HOUR OF DEATH 9/10/1967 3:55P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Church Home & Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Broadway & Fayette St. 35 Baltimore Md. 21231						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE S-05 D. STREET ADDRESS (If rural, give location) 1751 E. NORTH AVE			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 5 5 06	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN B.D. OF EDUC.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HAYES BOOKER				14. MOTHER'S MAIDEN NAME ANNA UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 23712 7046		17. INFORMANT ADDRESS ELNOCA BOOKER 1751 E. NORTH AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ME TASTATIC CA. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CANCER OF RECTUM CANCER OF PROSTATE						INTERVAL BETWEEN ONSET AND DEATH FEW MONTHS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 7/21/67				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PROSTATE		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO				21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 8 1967 to Sept 10 1967 , that (I) (we) last saw the deceased alive on Sept 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE László Kiraly M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 9/10/67			
23C. PHYSICIAN'S NAME (Type) LASZLO KIRALY M.D.						23D. ADDRESS 100 N. BROADWAY Bt-Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-14-7		24C. NAME of CEMETERY or CREMATORY Arbutus MEMO. PK.		24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MARSHALL W. JONES Jr. ADDRESS 1735 Harford Avenue 21213					

Church Home Hospital
 Broadway & Fayette St.
 Baltimore, Md. 21201
 1751 E. NORTH AVE
 BALTIMORE

MARRIED 25 OCT 1954
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 HAYES BOOKER
 ANNA UNKNOWN
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CANCER OF PROSTATE
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67 8761 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8761

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

~~ABRON~~

Aaron or Abron DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1967 10:29 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 325 E. Biddle St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

325 E. Biddle St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

July 8, 1967

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Shoe worker

10B. KIND OF BUSINESS OR INDUSTRY

Dittblin Shoe Co.

11. BIRTHPLACE (State or foreign country)

Warrenton N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wiley Davis

14. MOTHER'S MAIDEN NAME

Helena Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

22403 966

17. INFORMANT

Mary Davis 325 E Biddle St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

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19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept 15/67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

A. A. County Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 13 1967

24B. NAME OF REGISTRAR

A. A. County

24C. FUNERAL DIRECTOR

Milton E. Erickson 1129 N. Caroline St

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8762	
BIRTH NO. 67 8762		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Clara Agnes Potter		Sept. 11, 1967 12:25 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Pk. Drive		A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 6510 Banbury Road		53-00	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 3/12/89	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) NJ	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Gibbons		14. MOTHER'S MAIDEN NAME Mary Mc Cormick	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary insufficiency due to hydropneumothorax		CAUSE OF DEATH (A) DUE TO Sequellae of ruptured duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH Hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO ulcer		(C) Days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Multiple cardiopulmonary resuscitations		Hours	
19A. DATE OF OPERATION 9/10/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Thrombosis left femoral artery/ yes		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) (II in Baltimore City, give exact location)	
21C. WHERE DID INJURY OCCUR? (II in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Sept. 7 19 67 to Sept. 11 19 67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Sept. 7 19 67 to Sept. 11 19 67 , that (I) (we) last saw the deceased alive on Sept. 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Henry S. Crist M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23B. DATE SIGNED 9/12/67		23C. PHYSICIAN'S NAME (Type) Henry S. Crist, SA Surg (R)		23D. ADDRESS US PHS Hospital, Balto, 21211, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/67		24C. NAME OF CEMETERY or CREMATORY St. Peter's	
24D. LOCATION (City, town, or county) (State) New Brunswick, N. J.		25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8763				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8763	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Hasenkamp, Edgar</i>		2. DATE AND HOUR OF DEATH <i>8:30 9/11/67 8:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Md.</i>		B. COUNTY	
5. SEX <i>M</i>				6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>VICE-PRESIDENT</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>A.D. ANDERSON ENTERPRISES</i>		8. DATE OF BIRTH <i>8/31/98</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>				9. AGE (In years last birthday) <i>69</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Anton Hasenkamp</i>				14. MOTHER'S MAIDEN NAME <i>Anna O'Brecht</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>213-01-2128</i>		17. INFORMANT <i>MRS. ELIZABETH M. HASEN KAMP</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>42211</i>				A. CAUSE OF DEATH <i>Pulmonary embolism, massive, to distal</i>		INTERVAL BETWEEN DEATH AND EXAMINATION <i>2-3 hours</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				B. <i>Old Myocardial Infarction</i>		C. <i>ASCD With congestive heart failure</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>W.K.W.</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>9/2/67</i> to <i>9/11/67</i> , that (1) (we) last saw the deceased alive on <i>9/11/67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) did (did not) view the body after death.							
23A. SIGNATURE <i>H. F. Holcomb</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/11/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>H. F. Holcomb</i>				23D. ADDRESS <i>327 Stronman Lane Balto.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Entombment</i>		24B. DATE <i>9/14/1967</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Mausoleum Balto. Co., Md.</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co.</i>		ADDRESS <i>4905 York Rd. Balto. 12, Md.</i>	

W. F. Holcomb

Union Memorial

W. F. Holcomb

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W. F. Holcomb

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Reg. No. 67 8764	
BIRTH NO. 67 8764		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Edwards, Iona I.</i>		2. DATE AND HOUR OF DEATH <i>9/13/1967 16:45 H.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital</i>		A. STATE <i>Md.</i> B. COUNTY <i>Balt. City</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 12-02</i>			
		D. STREET ADDRESS (If rural, give location) <i>3405 Oakenshaw Place</i>			
5. SEX <i>F</i>	6. RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED (Specify)	8. DATE OF BIRTH <i>11/12/82</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED TEACHER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>EDUCATION</i>		11. BIRTHPLACE (State or foreign country) <i>STONEY POINT Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Brice W. Edwards</i>		14. MOTHER'S MAIDEN NAME <i>Mary Marshall</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-44-0959</i>		17. INFORMANT <i>Ethel E Edwards (Same)</i>	
18. <i>433.0</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Cardiac arrest</i>			
ANTECEDENT CAUSES		(B) <i>CHF</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>ASCVD</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>9/10 1967</i> to <i>9/13 1967</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>9/13 1967</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above (I) <i>(We)</i> <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>Barry J. Weckesser</i>				23B. DATE SIGNED <i>9/13/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>BARRY J. WECKESSER</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/15/1967</i>		24C. NAME of CEMETERY or CREMATORY <i>Woodlawn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore County, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i>			

File card, Iowa

Union Memorial
Hospital

F Conc

Brice W Edwards

Mary Marshall

E & Mel E Edwards (Grand)

Cardiac arrest

CHF
ASCVD

3402 Oakenshaw Place
Baltimore

11/2/83 84

Virginia

W.S.

Grand W Edwards

11/3

11/3

11/3

11/3

11/3/07

THE UNIVERSITY OF MARYLAND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8765				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8765	
1. NAME OF DECEASED (Type or Print) CARRIE E. VOGEL				2. DATE AND HOUR OF DEATH Sept. 9th, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 610 Nicoll Avenue-12				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 610 Nicoll Avenue-12			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Mar. 4, 1873	9. AGE (In years last birthday) 94	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-School			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Vogel			14. MOTHER'S MAIDEN NAME Elizabeth Strauss		17. INFORMANT Mr. Burton L. Morgan-610 Nicoll Ave-12		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no-			16. SOCIAL SECURITY NO. 216-54-2265-T		ADDRESS		
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Memia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Serile Arterio - Sclerosis				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Sept 9th 1967 , that (I) (we) last saw the deceased alive on Sept 9th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Paul M. Byerly M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 9/14/67			
23C. PHYSICIAN'S NAME (Type) Paul M. Byerly				23D. ADDRESS 5820 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME of CEMETERY or CREMATORY London Park Cemetery		24D. LOCATION (City, town, or county) (State) Balto.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR SEP 14 1967		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. 21212			

Memorandum
- Serials Section -
Division

Page 2

Subject

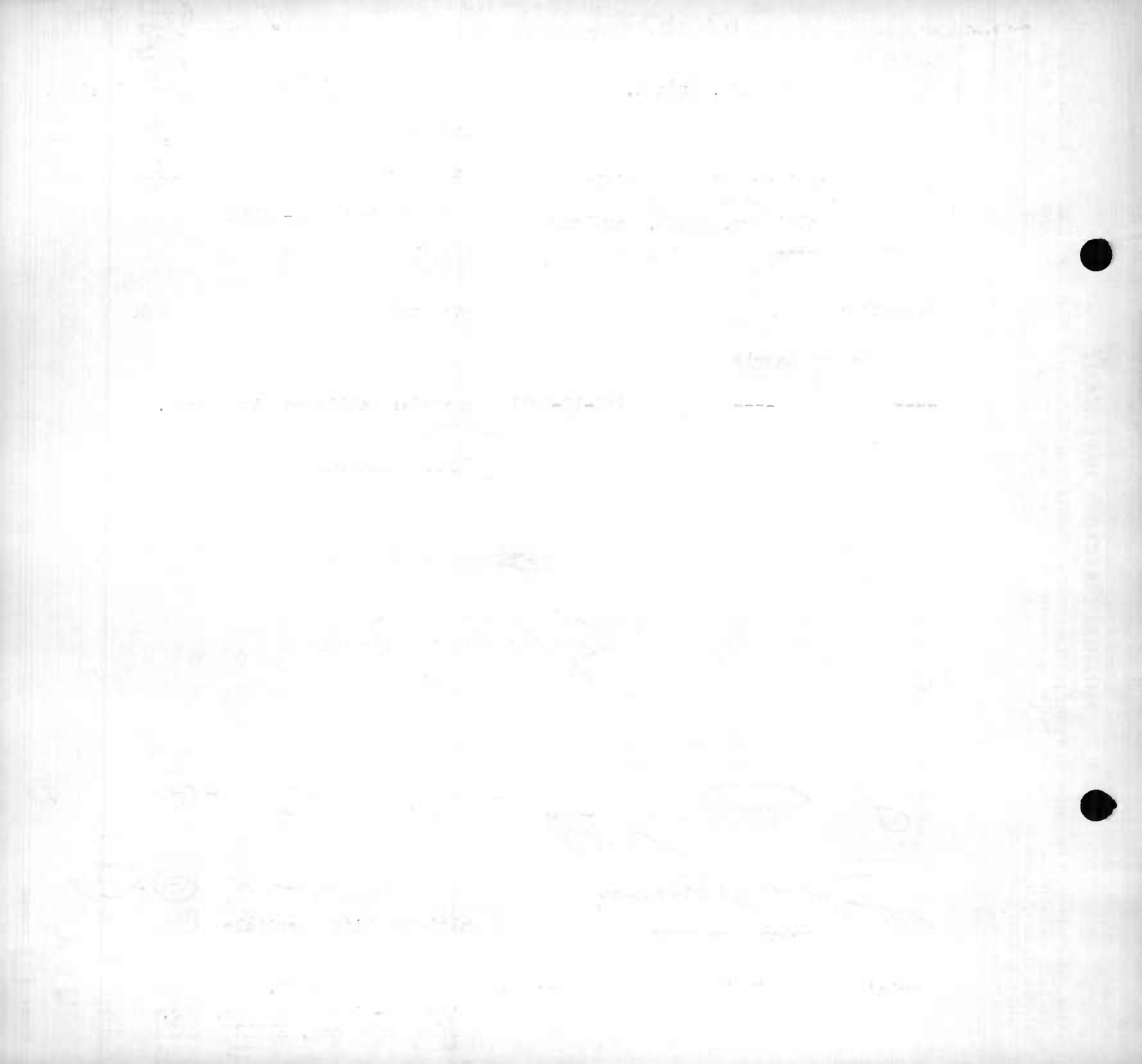
Memorandum

4/1/5

FUNERAL DIRECTOR: IMPORTANT

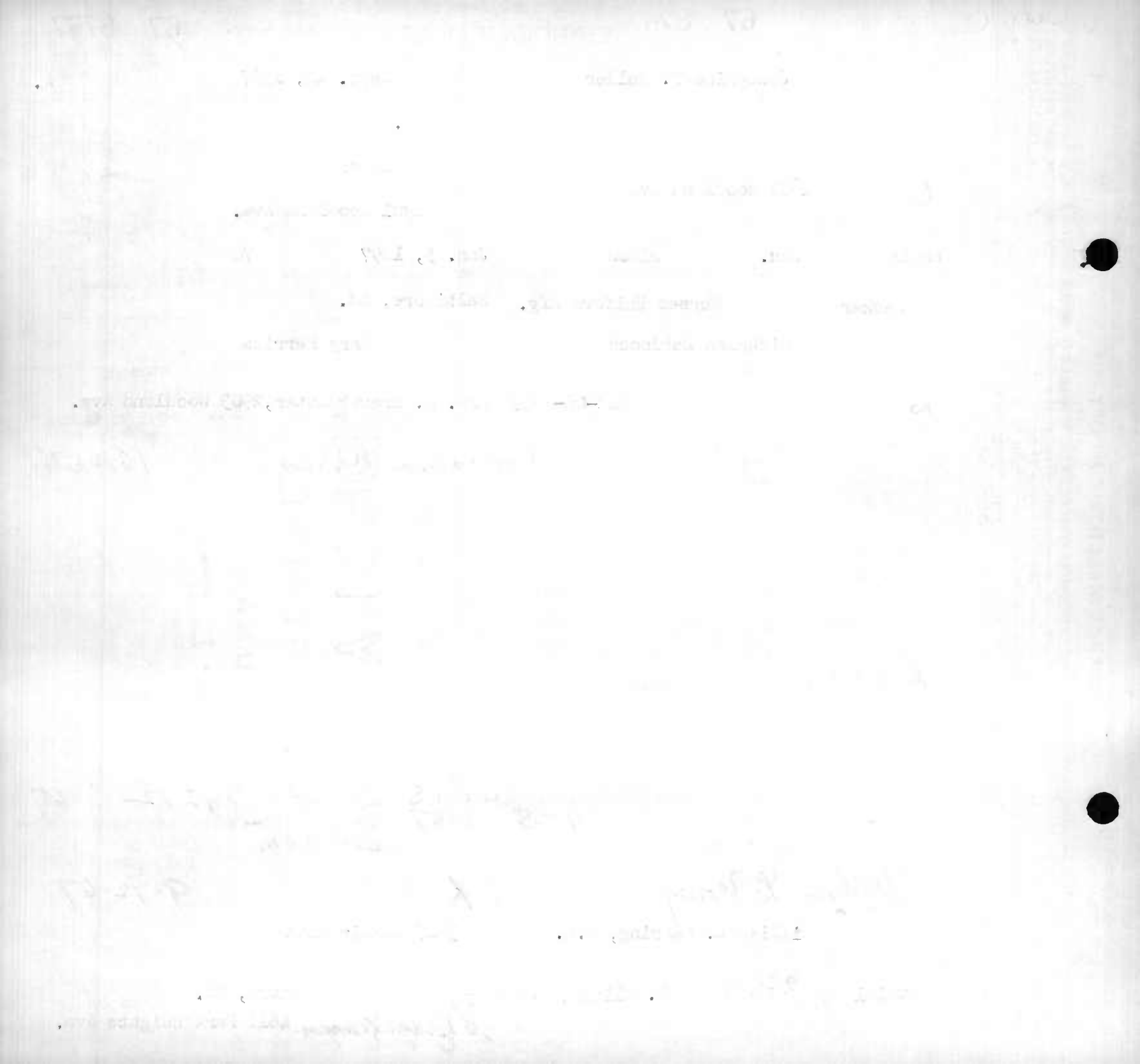
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8766	
BIRTH NO. 67 8766		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		THOMAS, Lula A.		9/9/67 4:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, 21224, Maryland			Maryland Baltimore 53-00		
5. SEX Female			6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed
8. DATE OF BIRTH 3/23/1887		9. AGE (In years last birthday) 80		10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert Laurie		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 231-10-1011		17. INFORMANT Records: Baltimore City Hospt.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C) #		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/11/67 to 9/9/67, that (I) (we) last saw the deceased alive on 9/9/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Zachary Grossman				23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) Zachary Grossman				23D. ADDRESS Baltimore City Hospitals	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME of CEMETERY or CREMATORY Baltimore	
24D. LOCATION Balto.		24E. NAME of REGISTRAR Mitchell-Wiedefeld Home, Inc.		24F. ADDRESS 6500 York Road, 21212	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR Mitchell-Wiedefeld Home, Inc.		25C. FUNERAL DIRECTOR 6500 York Road, 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8767					CERTIFICATE OF DEATH				
Registered No. 67 8767									
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Josephine T. Muller					Sept. 12, 1967				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 00 2901 Woodland Ave					A. STATE Md.				
					B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					27-16				
2901 Woodland Ave.									
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Female	Cau.	Widow		Jan. 5, 1897	70	Packer		Baltimore, Md.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Nicholas Boblooch					Mary Ferrica				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No					212-05-7935				
17. INFORMANT					ADDRESS				
Mrs. M. Krautblatter					2903 Woodland Ave.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) <u>Carcinoma Uterus</u>				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO				
II					INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					162 months				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
Dec 1966		Cancer							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from June 15 1964 to Sept 12 1967.									
that (I) (we) last saw the deceased alive on 9-8-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 3 AM									
23A. SIGNATURE					23B. DATE SIGNED				
William L. Fearing					9-12-67				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
William L. Fearing, M.D.					3025 Belair Road				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial		9/14/67		Mt. Olivet, Cemetery			Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
SEP 14 1967		Robert L. Fearing			B. Fearing			4611 Park Heights Ave.	



Released by Medical Examiner FM
FUNERAL DIRECTOR, IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-300		67 8768		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8768	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HEEDE, JEAN CONEY		9-9-67 1:45 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hosp.				A. STATE MD B. COUNTY			
CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
Baltimore				3223 St Paul Street			
5. SEX F.		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 4-13-10	
9. AGE (In years last birthday) 57		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Clothing Mfr.		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J.B. Coney		14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 212 20 4555		17. INFORMANT Frank C. Heede		ADDRESS 628 Yakona Rd.		21204	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) E916.10		CAUSE OF DEATH 3rd degree Burns		INTERVAL BETWEEN ONSET AND DEATH 3 days			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3223 St Paul St		12-02	
21D. TIME OF INJURY (APPROX.) 9 5 67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Unknown Clothes caught fire			
22. I certify that (X) (this hospital) attended the deceased from 9-6-67 to 9-9-67, that (X) (we) last saw the deceased alive on 9-9-67 and that in (X) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Felix J. Martin		23B. DATE SIGNED 9-9-67			
23C. PHYSICIAN'S NAME (Type) FELIX J. MARTIN		23D. ADDRESS THE UNION MEMORIAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-67	
24C. NAME of CEMETERY or CREMATORY Moreland Mem.Pk. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR Wm. E. Johnson	
25C. FUNERAL DIRECTOR Wm. E. Johnson		25D. ADDRESS 8521 Loch Raven Blvd.		25E. (04)			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8769		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8769	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lee, Glen A.		2. DATE AND HOUR OF DEATH 9-1-67 4:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-05	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		D. STREET ADDRESS (If rural, give location) 1829 N. CHARLES ST. #21202			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATE	8. DATE OF BIRTH 12-6-26	9. AGE (In years lost birthday) 40	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND W. VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FRITZ		14. MOTHER'S MAIDEN NAME VIRGIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 24 Nov 44		16. SOCIAL SECURITY NO. 404-24-9399		17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Staph. Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Staph Septicemia II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 9-8-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8-26 19 67 to 9-1 19 67 , that (I) (we) last saw the deceased alive on 9-1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE P. Desmond		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-1-67	
23C. PHYSICIAN'S NAME (Type) DR. P. DESMOND		23D. ADDRESS M.D. BCH-4940 EASTERN AVENUE -BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-8-67		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL BALTIMORE MD.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR W. E. Johnson	
25C. FUNERAL DIRECTOR W. E. Johnson		25D. ADDRESS 8021 Loch Raven Blvd.			

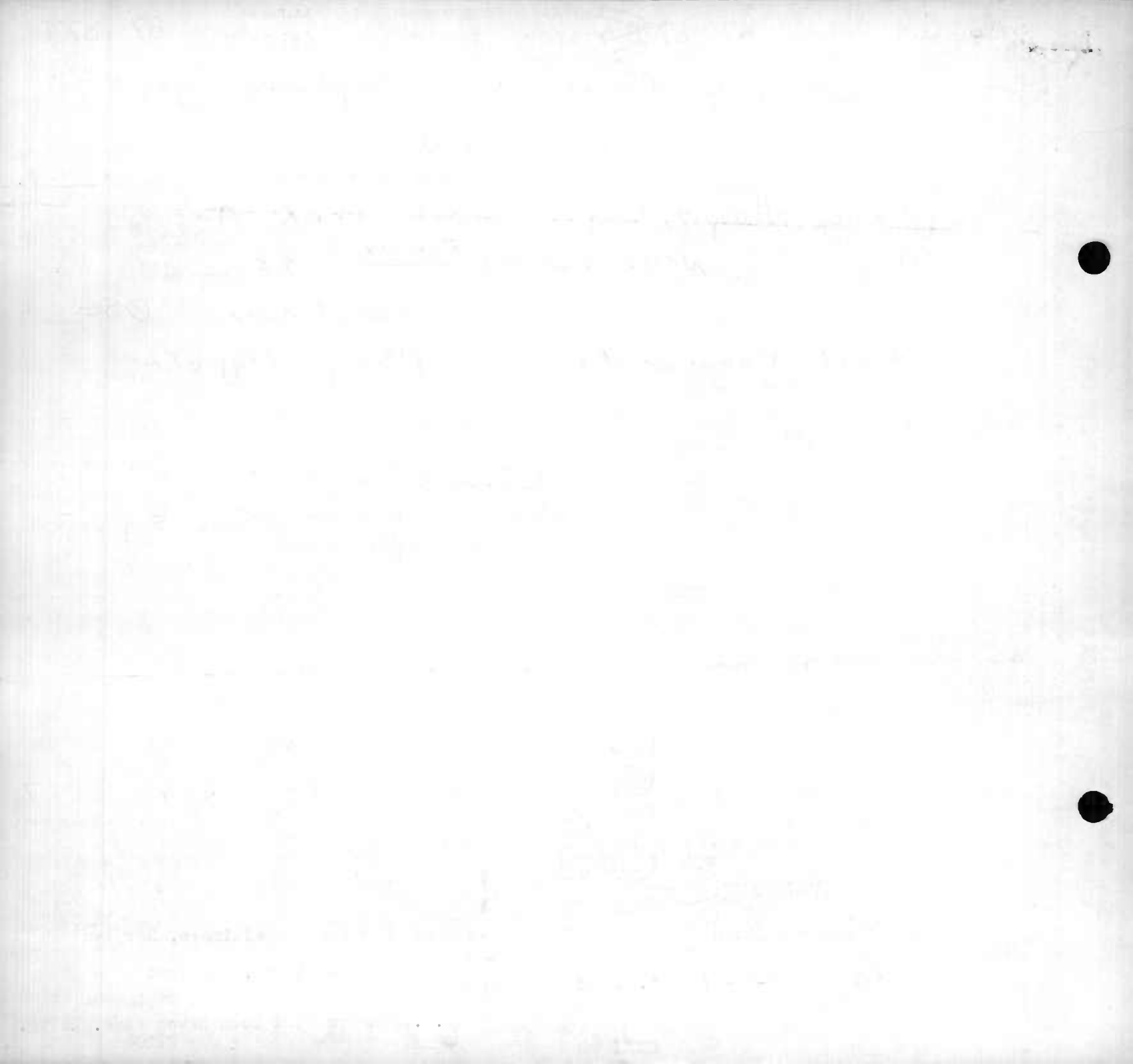
20th Nov 1914
Sally's letter

18th Nov

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8770
BIRTH NO. 67 8770		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Casimir Komorowski		
2. DATE AND HOUR OF DEATH September 9, 1967 5⁰⁰ PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 318 Park Ave.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 11-14	9. AGE (In years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ryszard Komorowski		
14. MOTHER'S MAIDEN NAME Mary Lebecka		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CONGESTIVE HEART FAILURE DUE TO Acute & Chronic (B) Arteriosclerotic & Hypertensive DUE TO Cardiovascular disease (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days / 5 years 5 years +
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9/8 19 67 to 9/9 19 67 , that (I) (we) last saw the deceased alive on 9/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Kenneth Stern		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/9/67
23C. PHYSICIAN'S NAME (Type) Kenneth Stern		23D. ADDRESS M.D. Mercy Hospital Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-12-67	24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Wm. E. Johnson 8521 Loch Raven Blvd. Balto.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 8771

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LAWRENCE HOFMAN.

2. DATE AND HOUR PRONOUNCED DEAD

September 9, 1967 7:05 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

36 Franklin Square Hospital D.O..A

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5202 Belleville Dr.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MACHINE OPP.

10B. KIND OF BUSINESS OR INDUSTRY

C.E.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

ROLAND L. HOFMAN JR. 266 RANDALL ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~XXXXXX~~

Ruptured aorta with

exsanguination due to trauma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Monroe and Hollins Sts.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9 9 67 6:50

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject driver in auto-truck collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

September 9, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/12/67

23C. NAME OF CEMETERY or CREMATORY

MEADOW RIDGE

23D. LOCATION

(City, town, or county)

(State)

ELK RIDGE, M.D.

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Paul E. Charney

ADDRESS

3617 Chestnut Ave

100

30

MAINTENANCE

MAINTENANCE

1

1

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

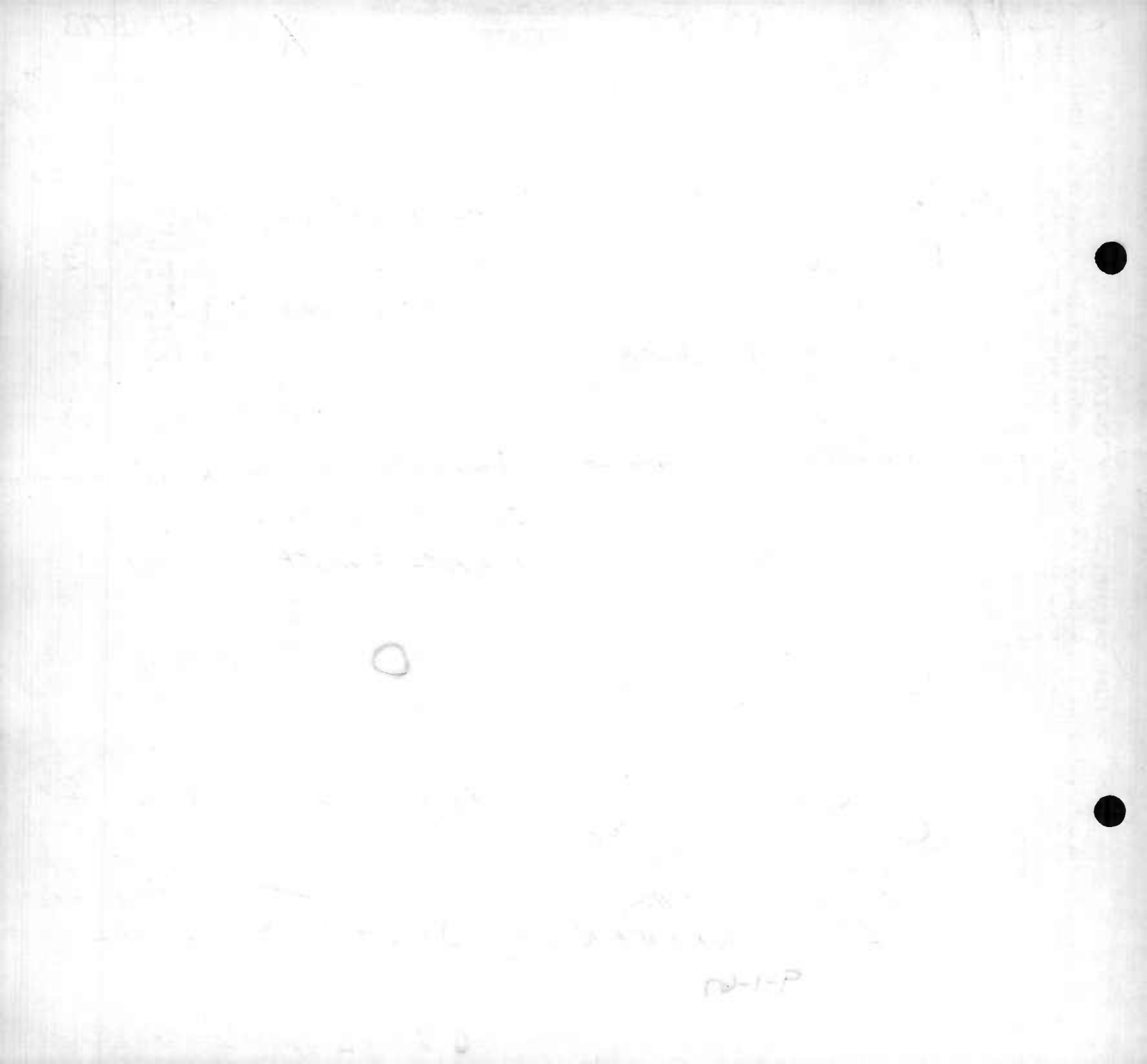
BALTIMORE CITY DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>67 8772</u>	
BIRTH NO. <u>67-16891</u>		67 8772			
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL BYRD</u>			2. DATE AND HOUR OF DEATH <u>8/23/67</u> <u>1 555</u> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-37</u> D. STREET ADDRESS (If rural, give location) <u>SINAI HOSPITAL 3302 Calver</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>8/21/67</u>	9. AGE (In years lost birthday) <u>0 1</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>EUGENE BYRD</u>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>HOSPITAL RECORD</u>		
18. <u>768.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <u>SEPSIS</u> DUE TO (B) <u>—</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>8/21</u> 19 <u>67</u> to <u>8/23</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/23</u> 19 <u>67</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan H. Mitnick</u> M.D.				23B. DATE SIGNED <u>8/23/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MITNICK</u>		23D. ADDRESS <u>SINAI HOSPITAL OF BALTO.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>9-1-67</u>	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>	

11-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

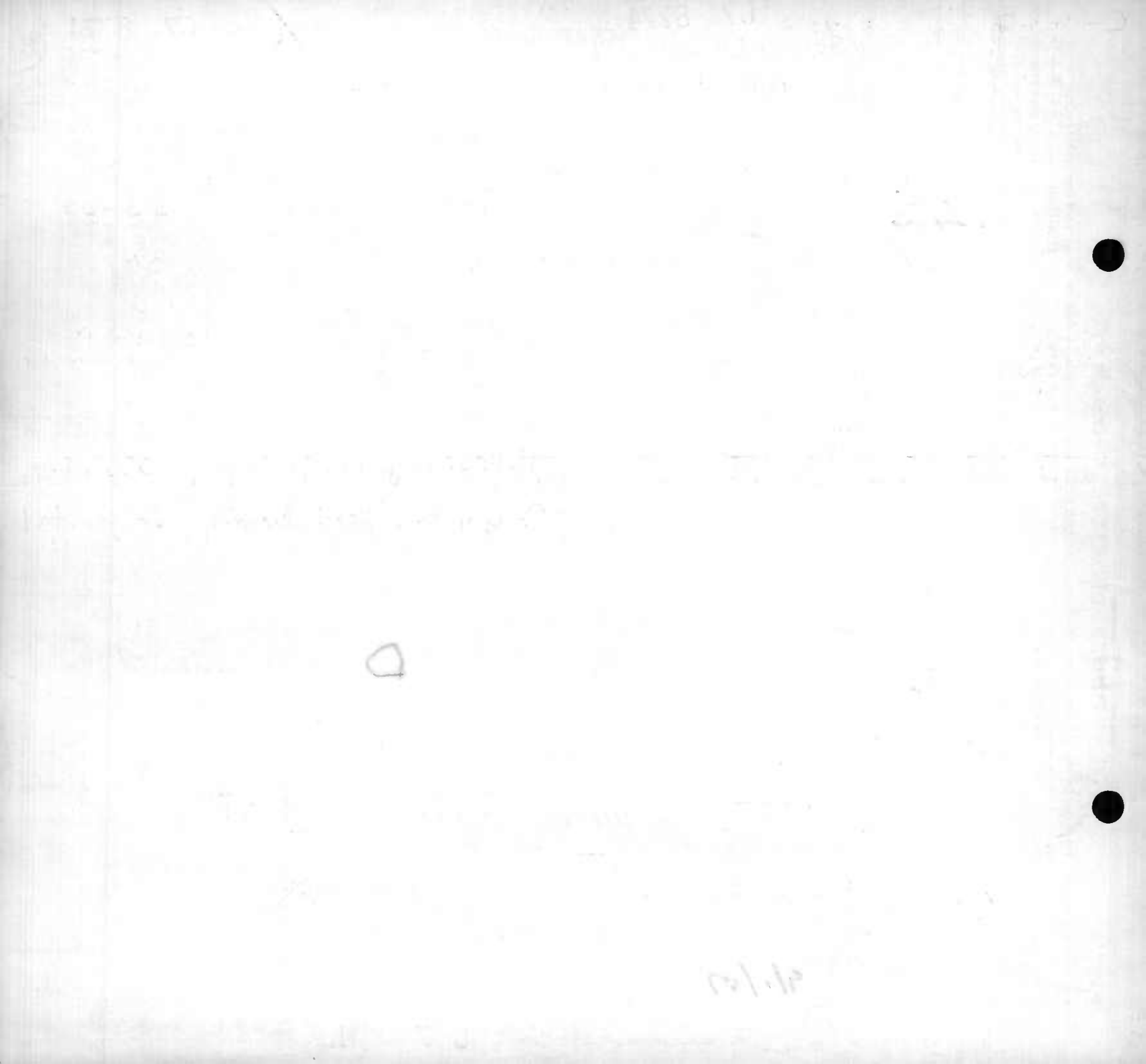
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 8773 4</u>	
BIRTH NO. <u>67-14218 67 8773</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED <u>Baby Girl Kushner</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <u>8/9/67</u> <u>6:30</u> <u>A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>4251 NAI Hospital</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore Co.</u>	
(If not in hospital) or institution, give street address or location		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
		D. STREET ADDRESS (If rural, give location) <u>4216 Colonial Rd</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8/9/67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>53</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Stuart Kushner</u>		14. MOTHER'S MAIDEN NAME <u>Cohen Edith</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. <u>762.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Dysmaturity</u>		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <u>INTRAUTERINE ANOXIA</u>	
		(B) DUE TO <u>PLACENTA INSUFF.</u>	
		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/9/67</u> to <u>8/9/67</u> , that (I) (we) last saw the deceased alive on <u>8/9/67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Lloyd Kramer</u>		23B. DATE SIGNED <u>8/9/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>LLOYD KRAMER</u>		23D. ADDRESS <u>UNIVERSITY MEDICAL SCHOOL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>9-1-67</u>		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Stachura</u>	
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-1375467 8774				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8774	
M.E. CASE NO. 391779 Hospital number				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Cross, Baby Girl</u>				2. DATE AND HOUR OF DEATH <u>8/4/67</u> <u>11:20P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD. (Neonate - Sinai Hospital of Baltimore)</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Co.</u> D. STREET ADDRESS (If rural, give location) <u>4339 Alan Drive</u> <u>53-00</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>7/7/67</u>	9. AGE (In years lost birthday) <u>—</u>	If Under 1 Yr. Months: <u>29</u>	If Under 24 Hrs. Hours: <u>—</u> Min. <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Neonate</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME			14. MOTHER'S M maiden name <u>Roberta Cross</u>			<u>4339 Alan Dr Baltimore, Md</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>—</u>		
18. <u>754.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Pulmonary Congestion</u> DUE TO (B) <u>Congenital Heart Disease</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>Congenital</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>D</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/7/67</u> 19 <u>67</u> to <u>8/4/67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11:19 p.m.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Frank Bouyer</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/4/67</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>—</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/1/67</u>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>SEP 14 1967</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67-17450 67 8775		CERTIFICATE OF DEATH		Registered No. 67 8775 4	
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Feldman</u>				2. DATE AND HOUR OF DEATH <u>5:05 P.M. 8/17/67</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hosp. Tel of Baltimore</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4503 Homer Ave</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8/17</u>		9. AGE (In years last birthday) <u>1</u>		If Under 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Sinai Hosp</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>		
13. FATHER'S NAME <u>Michael Feldman</u>				14. MOTHER'S MAIDEN NAME <u>Regina LueThje</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u> ADDRESS <u>as above</u>				
18. <u>261.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Abruptio Placentae</u>				(A) <u>Acute spontaneous PneumoThorax</u> DUE TO (B) <u>Ruptured Lung alveoli</u> DUE TO (C) <u>Prematurity [6 month gestation]</u>				INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>2</u> <u>None</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>None</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>				
22. I certify that (I) (this hospital) attended the deceased from <u>5:00pm Aug 17 19 67</u> to <u>5:05 pm Aug 17 19 67</u> , that (I) (we) last saw the deceased alive on <u>5:05 pm Aug 17 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Frank Bowyer</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <u>8/17/67</u>			
23C. PHYSICIAN'S NAME (Type) <u>Frank Bowyer</u> M.D.						23D. ADDRESS <u>Sinai Hospital Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/1/67</u>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BMD</u>					

9

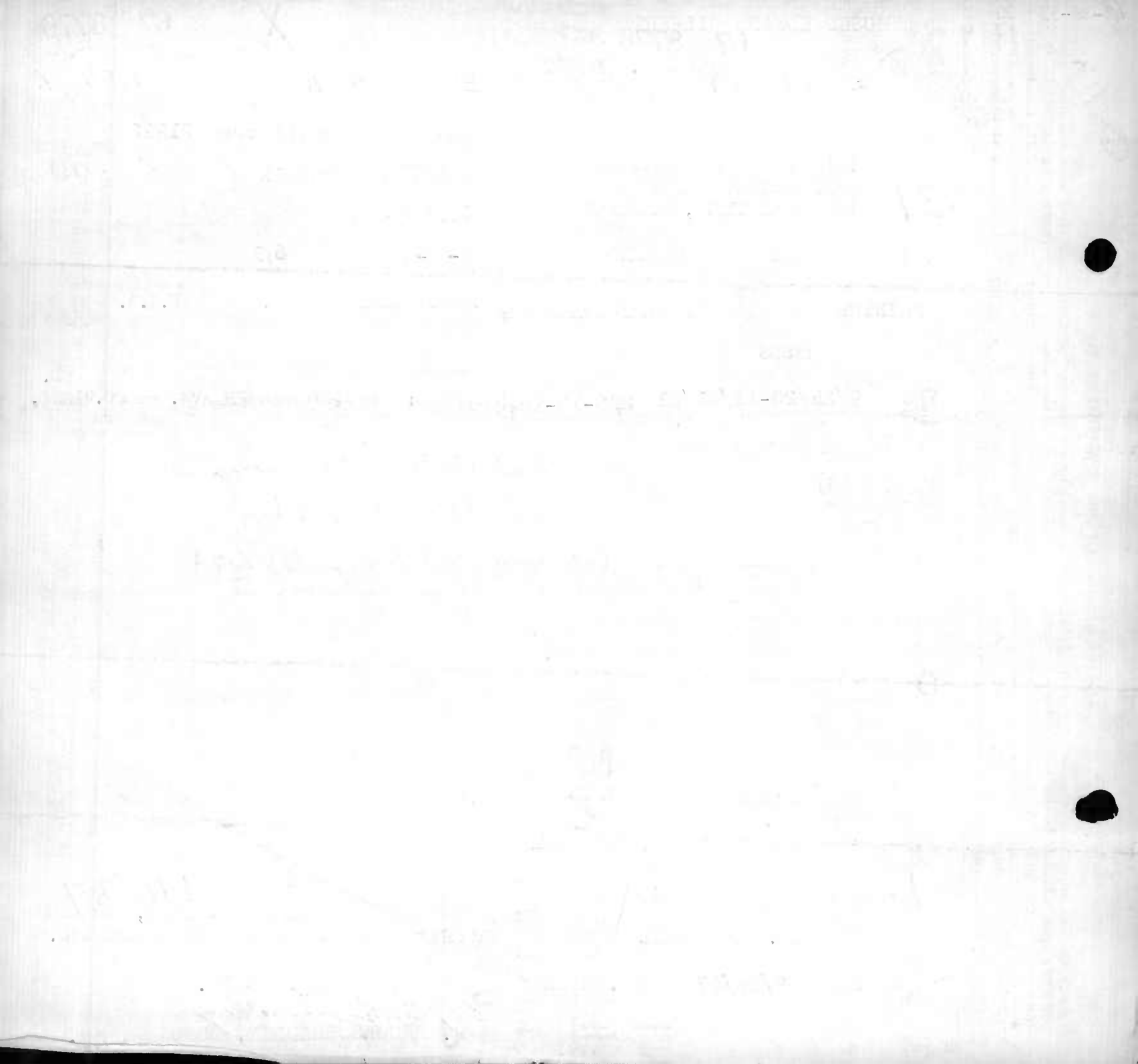
1851-1852

1851-1852

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 8776					Registered No. 67 8776					
MOSES EDWARD GILBERT										
M.E. CASE NO. 67 8776					1. NAME OF DECEASED MOSES E. GILBERT					
(Type or Print) GILBERT					2. DATE AND HOUR OF DEATH 9/11/67 1:55 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND					A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN 21222					
					D. STREET ADDRESS 1939 GUY WAY					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1-16-04		9. AGE (In years last birthday) 63		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10B. KIND OF BUSINESS OR INDUSTRY GENERAL PRINTING		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MOSES					14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 9/24/20-12/21/21					16. SOCIAL SECURITY NO. 206-10-9674		17. INFORMANT RECORDS: BCM 4940 EASTERN AVE. BALTO. 21224,			
18. 1870 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of the Bladder ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arrived at Hospital D.O.A. Not a medical examination case					CAUSE OF DEATH (A) DUE TO (B) DUE TO Arrived at Hospital D.O.A. Not a medical examination case					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/12 1966 to 11/19 1967 , that (I) (we) last saw the deceased alive on 8/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Terry E. Gagon					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9/11/67		
23C. PHYSICIAN'S NAME (Type) DR. TERRY GAGON					23D. ADDRESS BALTIMORE 21224, MARYLAND BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/15/67		24C. NAME OF CEMETERY or CREMATORY MT. ROSE			24D. LOCATION (City, town, or county) (State) YORK, PENNA.			
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR R. O. G. F. B. B.			25C. FUNERAL DIRECTOR W. Brooks Bradley			ADDRESS DUNDALK, MD.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8777				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8777	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CONNORS, GUSTINA LAURA				2. DATE AND HOUR OF DEATH SEPTEMBER 12, 1967 1:00P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 217 EDRIDGE WAY 21228			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOW	8. DATE OF BIRTH 3-24-91		9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MASSACHUSSETT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES TECCI CONNORS				14. MOTHER'S MAIDEN NAME LOUISE DRAGO CONNORS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 021-24-46304		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) insuperable Ce (R) breast ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Uraemia electrolyte imbalance				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 5, 1967 to SEPTEMBER 12, 1967 , that (I) (we) last saw the deceased alive on SEPTEMBER 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Steve C. Papatte				23B. DATE SIGNED 9/12/67		23C. PHYSICIAN'S NAME (Type) M.D. ST. AGNES HOSP; CATON & WILKENS AVES. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/67		24C. NAME OF CEMETERY or CREMATORY St. Mary's Cemetery		24D. LOCATION (City, town, or county) (State) Salem Mass.	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS FAIRLEY Cavanaugh-FUNERAL HOME			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8778	
BIRTH NO. 67 8778		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joy HENRY Bye Sr.		9-13-67 4:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
		A. STATE Maryland B. COUNTY 25-31			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
43 South Baltimore General Hosp.		Baltimore #21229			
D. STREET ADDRESS (If rural, give location)					
		4530 Parkton St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	Married	11-16-1901	65	U.S.A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur		Balt. Transit RETIRED		Neb.	U.S.A
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Bye			Dora Saffer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.		213-10-0500		Mrs Catherine Bye Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.11		ASCVD			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) CHF & Hypertension		20 A	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8-21 1967 to 9-13 1967, that we (we) last saw the deceased alive on 9-13 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John C. Butchart M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				9-13-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John C. Butchart				South Baltimore General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/16/67		New Cathedral Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 14 1967		John C. Butchart		John J. Cowanston Inc. 23, Md.	

Cell, Francis

Chaffin

W. G. H.

by

212-10-050 The Catherine Dye

Mr. -

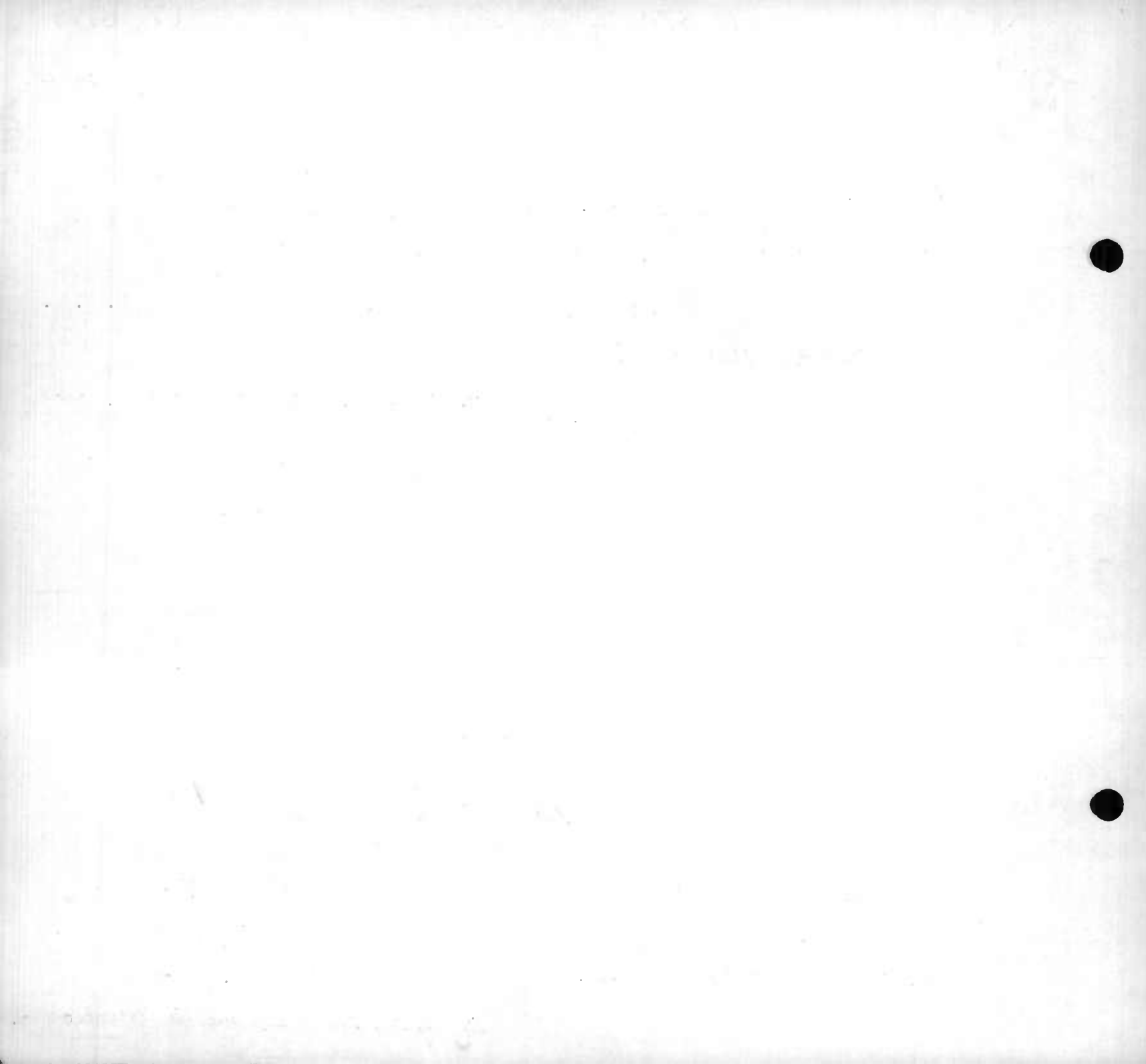
alone

James P. Miller, New-England, in
John D. Edwards, Sec. 22/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8779	
BIRTH NO. 67 8779		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED <i>Loretta D. Fosler</i>		2. DATE AND HOUR OF DEATH <i>9-13-67 9:00 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp</i>		A. STATE <i>Maryland</i> B. COUNTY <i>25-04</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21225</i>			
		D. STREET ADDRESS (If rural, give location) <i>3503 3rd. St.</i>			
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>9-6-1909</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Frank Norwood</i>			
14. MOTHER'S MAIDEN NAME <i>Dora</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mr. William E. Fosler 3503 3rd St. 21225</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i>		CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic Cardiovas. Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>9-11</i> 19 <i>67</i> to <i>9-13</i> 19 <i>67</i> . that the (we) last saw the deceased alive on <i>9-13</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Donald M. Wood</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-13-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Donald Wood</i>		23D. ADDRESS <i>South Baltimore General Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/16/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>McCully Funeral Home</i>		ADDRESS <i>237 Patapsco Ave.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8780		BALTIMORE CITY HEALTH DEPT. 67 8780		Registered No. 67 8780	
M.E. CASE NO.		1. NAME OF DECEASED BELL, WILLIAM R. JR.		2. DATE AND HOUR OF DEATH SEPTEMBER 12 1 3:55 P.M.	
3. PLACE OF DEATH BALTIMORE, MARYLAND					
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			5. CITY OR TOWN (If outside city limits, write RURAL and give township) 4111 Crestheights Rd.		
6. STREET ADDRESS (If rural, give location) Baltimore, Maryland #21215			7. DATE OF BIRTH 8-4-1885		
8. AGE (In years lost birthday) 82			9. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer B. & O. R. R.			10B. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Bell (Deceased)			14. MOTHER'S MAIDEN NAME Hannah ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. -		
17. INFORMANT BCH 4940 Eastern Avenue			ADDRESS RECORDS: Baltimore, Maryland #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma			INTERVAL BETWEEN ONSET AND DEATH unknown		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia + CHF					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from April 5 1967 to September 12 1967 , that (I) last saw the deceased alive on 9/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond J. LaSure M.D.				23B. DATE SIGNED 9/12/67	
23C. PHYSICIAN'S NAME (Type) Raymond J. LaSure				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/67		24C. NAME OF CEMETERY or CREMATORY Louisa Park Cem.	
24D. LOCATION (City, town, or county) 3801 Frederick Ave. Md.		24E. DATE REC'D BY HEALTH/DEPT. SEP 14 1967		24F. NAME OF REGISTRAR John J. Gowan	
24G. FUNERAL DIRECTOR John J. Gowan & Son Inc.		24H. ADDRESS 901 Hollins St. Baltimore, Md.			

V.S. 153 and Death Cert. 53-4492 for
Maude E. Bell - May 12, 1953 10-2-67 M.H.

10-2-67

10-2-67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8781	
BIRTH NO. 67 8781		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TILLIE WEISSMAN		2. DATE AND HOUR OF DEATH 9-12-67 9 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33		A. STATE MARYLAND B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 15 3-01			
		D. STREET ADDRESS (If rural, give location) 2449 SHIRLEY AVE. 1404 E. Lombard St			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED.	8. DATE OF BIRTH 7-6-1892	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EMENIEL HARRIS		14. MOTHER'S MAIDEN NAME RACHEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MORRIS WEISSMAN ADDRESS SAME	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Aspiration, vomitus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD Many yr		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 9/12/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/1 1967 to 9/12 1967 , that (I) (we) last saw the deceased alive on 9/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas C. Butler M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9/12/67	
23C. PHYSICIAN'S NAME (Type) THOMAS C. BUTLER				23D. ADDRESS 601 N. BROADWAY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/67		24C. NAME OF CEMETERY or CREMATORY Bnai Israel	
24D. LOCATION (City, town, or county) Balta		24E. (State) MD			
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC ADDRESS Garners	

ASCD
Administration of
10 years

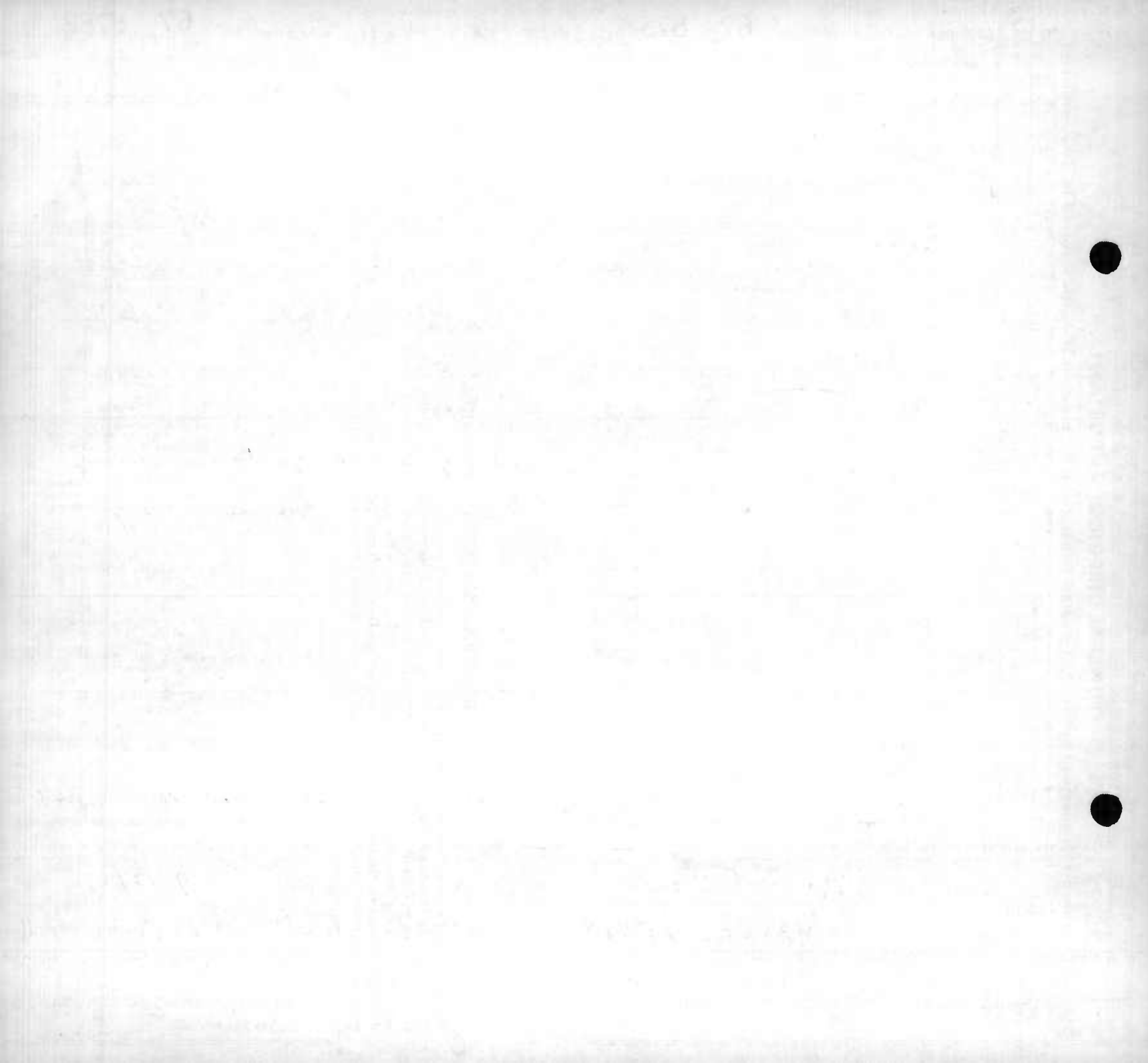
11/15/67

COL W. BROWN

THOMAS C. BUTLER
THOMAS C. BUTLER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

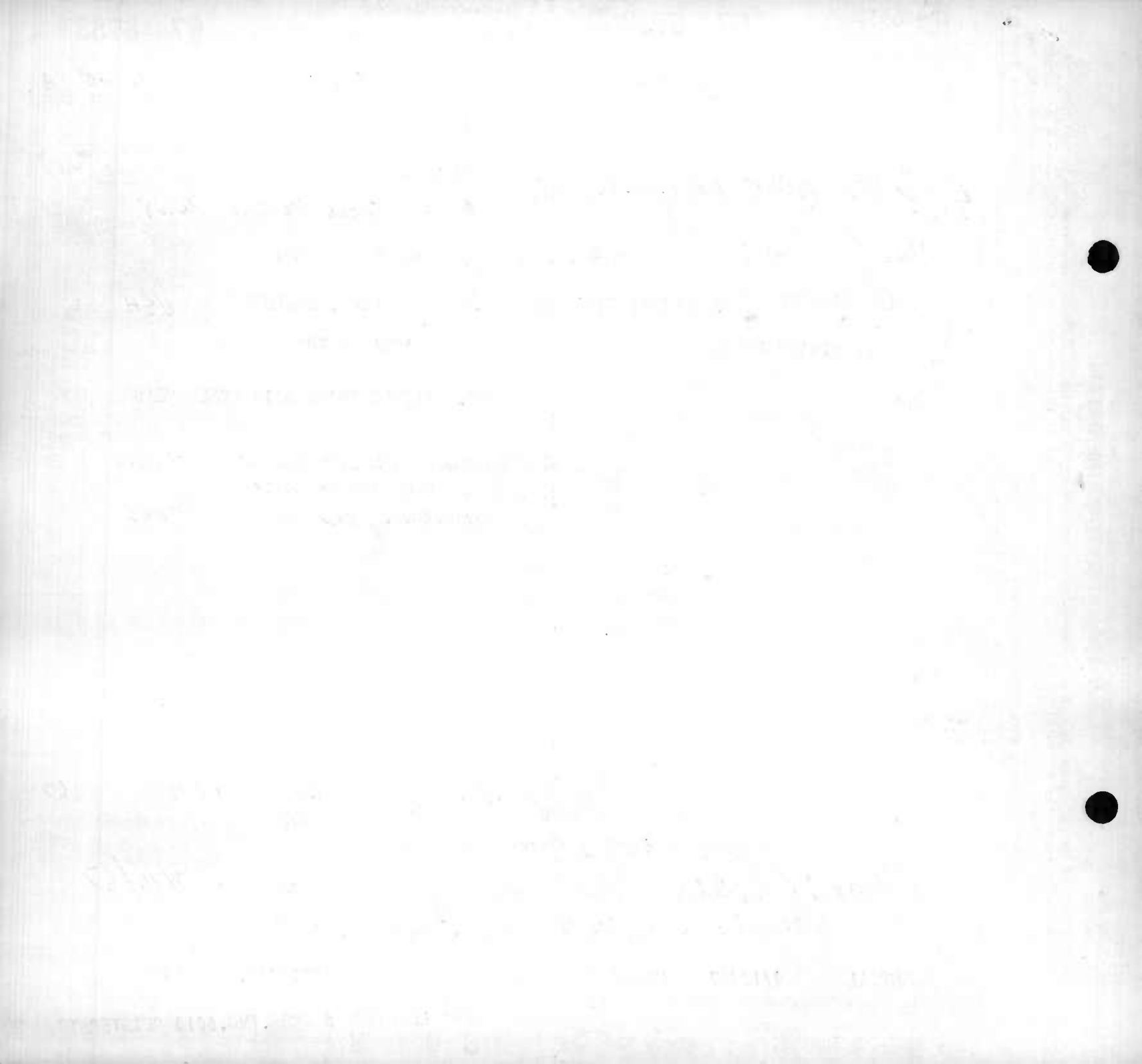
BIRTH NO. 67 8782		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8782	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) SAM ROSENFELD		
2. DATE AND HOUR OF DEATH Sept 11, 1967 11 P M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2632 OSWEGO AVE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO			D. STREET ADDRESS (If rural, give location) 2632 OSWEGO AVE		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY 11, 1911	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LOU		14. MOTHER'S MAIDEN NAME MINNIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 062-03-9505		17. INFORMANT ROSE ROSENFELD ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Acute myocardial Infarction 1 day		
			(B) Arteriosclerotic Heart Disease 2 years		
			(C) none		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			none		
19A. DATE OF OPERATION 9/12/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (the hospital) attended the deceased from July 30, 1965 to Sept 11, 1967 that (I) was lost saw the deceased alive on Sept 11, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.			
23A. SIGNATURE Manuel Levin M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/12/67		23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D.	
23D. ADDRESS 4818 Reisterstown Rd Balto Md		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67	
24C. NAME OF CEMETERY or CREMATORY Hebrew Young Man		24D. LOCATION (City, town, or county) Balta		24E. STATE Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sydney S. Lewis & Son, Inc ADDRESS Garrison	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-652 67 8783		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8783	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
67 8783				ELLIOT C. FRANK	
2. DATE AND HOUR OF DEATH		9/10/67 11:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MD			
42 SINAI HOSP OF BALTO, INC.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 27-15			
D. STREET ADDRESS (If rural, give location)		6210 GREEN MEADOW PKWY			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/27/07	9. AGE (In years last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MANAGER
10B. KIND OF BUSINESS OR INDUSTRY UNIVERSAL PAPER CO		11. BIRTHPLACE (State or foreign country) WEST. VA., KEYSTONE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FERDINAND FRANK			14. MOTHER'S MAIDEN NAME ANNA CANTOR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. MILDRED FRANK 6210 GREEN MEADOW PKWY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I VENTRICULAR FIBRILLATION 20 DUE TO ACUTE MYOCARD INFARCTION 10 DAYS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 10 DAYS 10 DAYS		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/29 to 9/10, 1967, that (we) last saw the deceased alive on 9/10, 1967, and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE Edward R. Cohen				23B. DATE SIGNED 9/10/67	
23C. PHYSICIAN'S NAME (Type) EDWARD R COHEN				23D. ADDRESS SINAI HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/12/67		24C. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MENS	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967			
25B. NAME OF REGISTRAR Robert E. Stephens		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-522		67 8784		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8784	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) REBA ZAYONCHICK				2. DATE AND HOUR OF DEATH SEPTEMBER 10/67 4 ⁵⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
00 3620 SPAULDING AVENUE				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		27-18	
				D. STREET ADDRESS (If rural, give location) 3620 SPAULDING AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/8/1915	9. AGE (In years last birthday) 52	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL LEVIN				14. MOTHER'S MAIDEN NAME LENA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. HARRY ZAYONCHICK 3620 SPUALDING AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Metastatic Carcinoma DUE TO (B) Carcinoma of Lungs DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 19 51 to Sept. 10 1967, that (I) (we) lost saw the deceased alive on Sept. 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.							
23A. SIGNATURE Julius C. Gluck				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/10/67	
23C. PHYSICIAN'S NAME (Type) JULIUS GLUCK				23D. ADDRESS M.D. 5356 REISTERSTOWN ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/11/67		24C. NAME OF CEMETERY or CREMATORY SHAAREI TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR Robert E. Felsman		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			

Metastatic Carcinoma
Carcinoma of lung

21 Sept 10

Sept 10

John C. Jones

9/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8785 CERTIFICATE OF DEATH					Registered No. 67 8785				
1. NAME OF DECEASED (Type or Print) ISADORE TRIEBWASSER					2. DATE AND HOUR OF DEATH SEPTEMBER 12, 1967 12¹⁰ A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-20 D. STREET ADDRESS (If rural, give location) 3120 PARKINGTON AVENUE APT C				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME IGNATZ TRIEBWASSER					14. MOTHER'S MAIDEN NAME Sarah				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT GOLDSTEIN FUNERAL HOME			ADDRESS 6410 N. BROAD ST. PHILADELPHIA, PA.		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 34 hrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9/12/67 19 to 9/14/67 19, that (I) (we) last saw the deceased alive on 9/14/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above: (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Joseph Shear M.D.					Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 9/12/67	
23C. PHYSICIAN'S NAME (Type) DR. JOSEPH SHEAR					23D. ADDRESS M.D. 6715 PARK HEIGHTS AVENUE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL & REMOVAL		24B. DATE 9/12/67		24C. NAME OF CEMETERY OR CREMATORY MONTIFIORE CEMETERY, PHILADELPHIA, PENNSYLVANIA		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR R. E. Johnson		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REISTERSTOWN RD			

1/10/10

Handwritten notes, possibly "Handwritten notes" and "Handwritten notes".

1/10/10

1/10/10

Handwritten signature or name.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RUTH

ARRINGTON

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1967

7:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

00 801 W. Lexington St. (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

801 W. Lexington St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

6/15/1903

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Florida

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. Anderson - 2536 Hartford Rd.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

9/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/14/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary

23D. LOCATION (City, town, or county)

A.A. Co

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1967

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Marshall W. Long Jr

ADDRESS

1735
HARTFORD AVE

Winston in the 1st district
AA C
MS
MS

Frank 11/1/23 MTC colony

AA C

MS
MS

for laboratory. 2122 MTC colony

Chickens

Florida

6/12/1903

W. Wood

Donor's

Chickens

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 8787		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 8787	
1. NAME OF DECEASED (Type or Print) LEWIS, CHARLES						2. DATE AND HOUR OF DEATH 9/12/67 6 30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 833 W. FAYETTE ST., 21201			
5. SEX MALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE		8. DATE OF BIRTH 5/21/40	9. AGE (In years last birthday) 27	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DIABETIC KETO ACIDOSIS INTERVAL BETWEEN ONSET AND DEATH ? 2 days									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9/12 19 67 to 9/12 19 67 , that (I) (we) last saw the deceased alive on 9/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Oscar E. Fernandini M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 9/12/67			
23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDINI M.D.						23D. ADDRESS Lutheran Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Buried		9/16/67		St. Charles Cemetery		Reisterstown, Maryland			
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
SEP 11 1967		Robert E. Galloway		Paul R. Galloway		1712 W. North			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8788</u>	
BIRTH NO. <u>140</u>		67 8788		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ELLIS WESLEY</u>			2. DATE AND HOUR OF DEATH <u>9-6-67</u> <u>18:00 AM</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>238 WILSON STREET</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>6-13-09</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Mary Manning</u> ADDRESS <u>1152 N Stricker St</u>	
18. <u>163 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <u>CANCER OF LUNG</u> DUE TO (B) _____ DUE TO (C) _____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-6-67</u> 19 to <u>9-6-67</u> 19, that (I) (we) last saw the deceased alive on <u>9-6-67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dennis H. Tyres</u>				23B. DATE SIGNED <u>9-6-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>DENNIS H. TYRES</u>				23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/9/1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION <u>A A County Md</u>		24E. STATE (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1967</u>		25B. NAME OF REGISTRAR <u>Adolphus Walstead</u>		25C. FUNERAL DIRECTOR <u>Adolphus Walstead</u> ADDRESS <u>1206 W North Ave</u>	

W. B. D. 1892

H-200

67 8789 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8789

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ADELL

HICKS

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1967 1:22 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Fulton Avenue & Lafayette St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1622 N Smallwood St

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12/25/16

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Florida

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr Thomas Hicks, same

ADDRESS

18. E 983 X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Subdural Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Fulton Ave & Lafayette St. 16-04

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9/11/67 1:22 A.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Beaten

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

9/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/15/67

23C. NAME of CEMETERY or CREMATORY

National Cemetry

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1967

24B. NAME OF REGISTRAR

Robert E. Fairley

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

20/10/1944

WALLACE FORBES

NEW YORK



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 8790		67 8790	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Thelma L. Gordon			September 9, 1967 6:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
(If not in hospital or institution, give street address or location)			B. COUNTY		
1814 Moreland Avenue Baltimore, Maryland 21216			Maryland		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			Baltimore		
D. STREET ADDRESS (If rural, give location)			1814 Moreland Ave		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Colored	Married	Oct. 1, 1921	45	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Maryland		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Abe Laws			Emma Reid		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
					Mr. Stanley M. Gordon 1814 Moreland Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Pulmonary Infarction		Sudden
ANTECEDENT CAUSES			(B) Ch. Pulmonary Emphysema & chronic Pulm. hypertension		years
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Rt. heart failure		years
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
None					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/8 1967 to 9/1 1967, that (I) (we) last saw the deceased alive on 9/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Louis V. Blumberg				9/11/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Louis V. Blumberg, M.D.				3502 W. Rogers Ave Baltimore Md 21215	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		9-13-67		Baltimore National	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore, Maryland		SEP 14 1967		Arlington S. Phillips	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 14 1967		Arlington S. Phillips		1727 N. Monroe St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 8791	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 8791</p> <p>M.E. CASE NO. 655</p> <p>1. NAME OF DECEASED (Type or Print) LEWIS TRAYNHAM, (JOHN)</p> </div> <div> <p>2. DATE AND HOUR OF DEATH SEPT. 9, 1967 3:25 p.m.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>46 LUTHERAN HOSPITAL BALTIMORE, MARYLAND</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE Baltimore B. COUNTY 15-03</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p>D. STREET ADDRESS (If rural, give location) 1610 N. Smallwood St., #16</p>		
5. SEX M	6. RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 12/24/06	9. AGE (In years last birthday) 60	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Traynham			14. MOTHER'S MAIDEN NAME Ila Drumwright		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217-01-2788		
17. INFORMANT Martha Traynham			ADDRESS Same		
<p>18. I 199.1 I 217-01-2788</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>CAUSE OF DEATH</p> <p>(A) Carcinomatosis, primary Neck</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p>		
<p>INTERVAL BETWEEN ONSET AND DEATH</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
<p>22. I certify that (I) (this hospital) attended the deceased from Sept 9 19 67 to 19 , that (I) (we) last saw the deceased alive on D.O.A. 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE Angel H. Roque				23B. DATE SIGNED 9/9/67	
23C. PHYSICIAN'S NAME (Type) ANGEL H. ROQUE				23D. ADDRESS LUTHERAN Hospital, Baltimore, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR John E. Traynham		25C. FUNERAL DIRECTOR Arlington S. Phillips	
				ADDRESS 1727 N. Monroe St.	

THE HALL

THE HALL

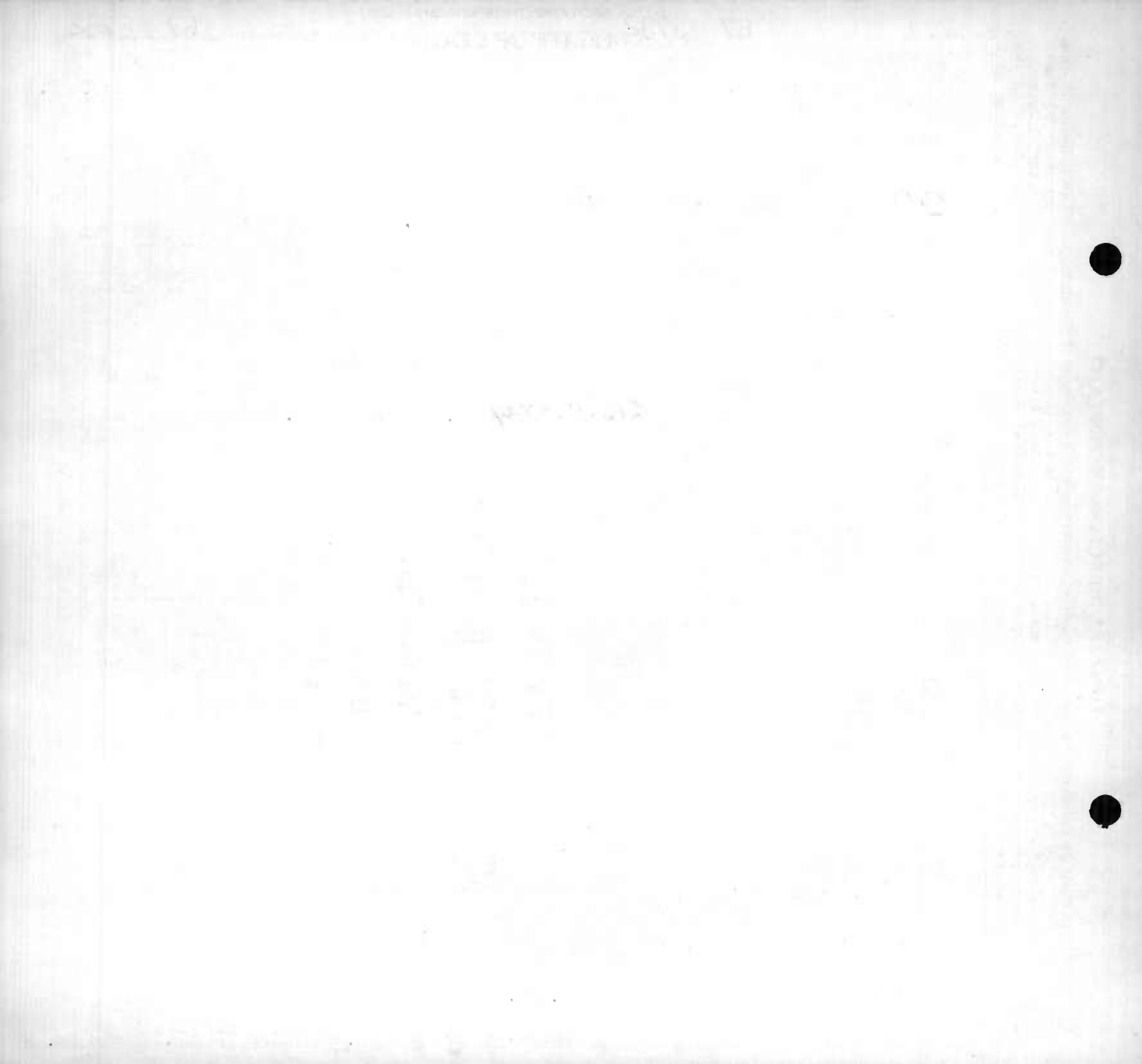
THE HALL

THE HALL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8792	
BIRTH NO.		67 8792		CERTIFICATE OF DEATH	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)		
			Ernest McGee		
2. DATE AND HOUR OF DEATH			September 10, 1967 1:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 917 N. Appleton Street Baltimore, Maryland 21217			A. STATE Maryland		
			B. COUNTY		
5. SEX Male			6. RACE Colored		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH April 15, 1908		
9. AGE (In years last birthday) 59			10. CITIZEN OF WHAT COUNTRY? USA		
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ozie McGee			14. MOTHER'S MAIDEN NAME Fronie Presley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-10-5834		
17. INFORMANT Mrs. Christophine R. McGee			ADDRESS same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Carcinomatosis (B) DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH 7 months					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 24 1967 to Sept 10 1967, that (I) (we) last saw the deceased alive on Sept. 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot				23B. DATE SIGNED 9/11/67	
23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT				23D. ADDRESS 3817 COPLEY RD. BALTO. 15, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 14 1967		24F. NAME OF REGISTRAR Arlington S. Phillips	
24G. FUNERAL DIRECTOR Arlington S. Phillips		24H. ADDRESS 1727 N. Monroe St.			



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H-325

67 8793 BALTIMORE CITY HEALTH DEPARTMENT

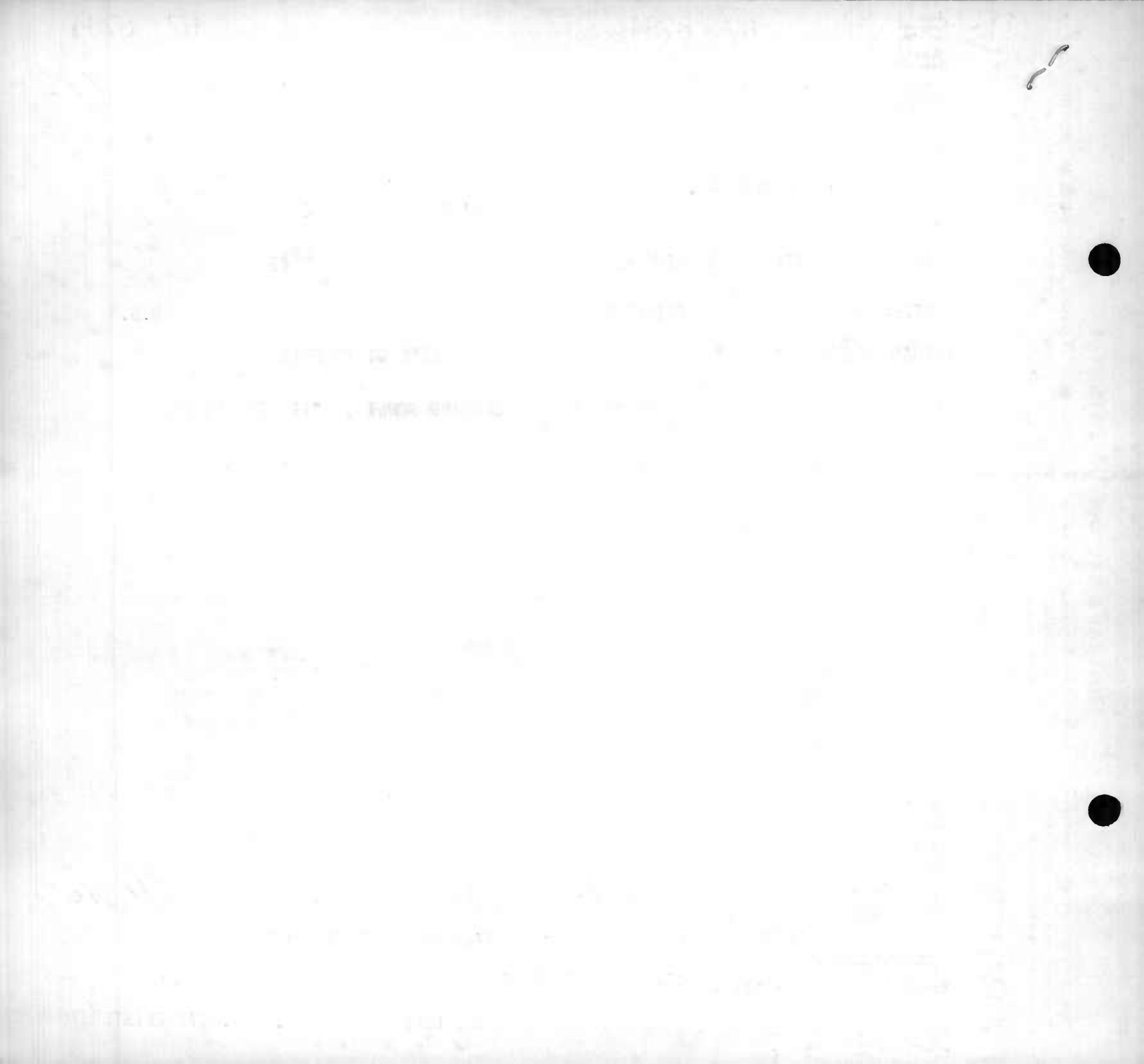
67 8793

BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) LUCY HUTCHINSON			2. DATE AND HOUR PRONOUNCED DEAD September 10, 1967 12:25 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-04		
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA)			C. CITY OR TOWN (If outside corporate limits, with RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1009 N. Wolfe St.		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-8-1904	9. AGE (in years last birthday) 53	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Durham, N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dock Lyde		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Ramish Hutchinson 1009 N. Wolfe	
18. 3-3-3		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Death During Epileptic Seizure DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pseudobulbar Palsy			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/11/67	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9-14-67		23C. NAME of CEMETERY or CREMATORY Carver Memorial PK.	
23D. LOCATION (City, town, or county) (State) Laurel, Maryland		24A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		24B. NAME OF REGISTRAR R. E. Farber	
24C. FUNERAL DIRECTOR Randolph Collick		24D. ADDRESS 2431 E. Oliver St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8794	
BIRTH NO. 67 8794		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) REV. HARRY SCHEIN		2. DATE AND HOUR OF DEATH SEPTEMBER 13, 1967 9 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 00 5105 ELMER AVE.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 5105 ELMER AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 83	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REVEREND		10B. KIND OF BUSINESS OR INDUSTRY RELIGION	11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME NATHAN SCHEIN			14. MOTHER'S MAIDEN NAME BLEME DISTENFELD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS BERNARD SCHEIN, 715 STURGIS PLACE		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 hr</i>	
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov - 1958</i> to <i>Sept 13 1967</i> , that (I) (we) last saw the deceased alive on <i>Sept 11 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lester Kolman</i> M.D.				23B. DATE SIGNED <i>9/13/67</i>	
23C. PHYSICIAN'S NAME (Type) LESTER KOLMAN				23D. ADDRESS 3700 PARK HEIGHTS AVENUE	
24A. REMOVAL (Specify)		24B. DATE 9/14/67		24C. NAME OF CEMETERY or CREMATORY CHEVRA KADISHA RISHIN L'TZION	
24D. LOCATION (City, town, or county) (State) JERUSALEM ISRAEL		25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967			
25B. NAME OF REGISTRAR <i>2256 J. J. J.</i>		25C. FUNERAL DIRECTOR ADDRESS SOI LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8795		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8795	
M.E. CASE NO.			1. NAME OF DECEASED		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Mrs. Julia Beck			Sept. 12-67 3 ⁵⁰ PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
34 Bon Secours Hospital.			Md. 20-02		
5. SEX F			6. RACE C		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W			8. DATE OF BIRTH 6-18-02		
9. AGE (In years last birthday) 65			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
11. BIRTHPLACE (State or foreign country) VIRGINIA			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles Clark			14. MOTHER'S MAIDEN NAME Betty Fitzgerald		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. None		
17. INFORMANT Julia Wiggins 13 N. Catherine St.			ADDRESS		
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Septicemic - Arteriosclerosis Cerebrovascular accident.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Advanced aged - Generalized arteriosclerosis		
19A. DATE OF OPERATION 7-12-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of Right leg		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 9th 1967 to Sep. 12 1967, that (I) (we) last saw the deceased alive on Same day 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did-not) view the body after death.					
23A. SIGNATURE M. Sarkarati				23B. DATE SIGNED Sep. 12, 1967	
23C. PHYSICIAN'S NAME (Type) Mehdi SARKARATI				23D. ADDRESS M.D. Bon Secours Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped		24B. DATE 9/14/1967		24C. NAME OF CEMETERY OR CREMATORY Bellegrave Cem.	
24D. LOCATION Danville Va.		24E. DATE REC'D BY HEALTH DEPT. SEP 14 1967		24F. NAME OF REGISTRAR R. B. E. H. H. H.	
24G. FUNERAL DIRECTOR Williams Funeral Home		24H. ADDRESS 319 N. Schenck St.			

General ledger

Month of June

Expenses - Hotel

June 1st - General ledger

Expenses of June 1st

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 8796	
67 8796											
BIRTH NO.											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Layfield Barbara L. Layfield						2. DATE AND HOUR OF DEATH 9.13.67 4.10 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland general hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-02					
5. SEX Female						6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 06-11-96	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None						10B. KIND OF BUSINESS OR INDUSTRY Housewife		9. AGE (In years last birthday) 71		11. BIRTHPLACE (State or foreign country) MD Baltimore	
13. FATHER'S NAME Alex Carr Dec						14. MOTHER'S MAIDEN NAME Catherine Hamilton Dec					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. 217-52-5778		17. INFORMANT Mrs. Joan Schmidt		ADDRESS 4524 Parkside Drive	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebro vascular Thrombosis						(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) general Arterio sclerosis DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						(C)					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 8-12-67 19 to 9-13-67 19, that (1) (we) last saw the deceased alive on 9-11-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Cyrus Makoui								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/13/67	
23C. PHYSICIAN'S NAME (Type) CYRUS MAKOU								23D. ADDRESS M.G.H. 827 Linden Ave Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-16-1967		24C. NAME of CEMETERY or CREMATORY Baltimore				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967				25B. NAME OF REGISTRAR Robert E. Spelman				25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.			
								ADDRESS 1901-07 Eastern Ave.			

James L. Taylor, Jr.

Reference

Reference

Mr. J. L. Taylor, Jr.

Reference

Mr. J. L. Taylor, Jr.

BIRTH NO. 67 12069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8797

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOANNE

Lynn

MILLER

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1967

11:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

BALTO. Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

605 Railroad St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

June 22, 1967

9. AGE (In years
last birthday)

30 days

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Zigmund Miller

14. MOTHER'S MAIDEN NAME

Josephine Lepkowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Zigmund Miller Railroad Ave., White Marsh, Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial Pneumonitis (SDII)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

9/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-12-1967

23C. NAME of CEMETERY or CREMATORY

Sacred Heart

23D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1967

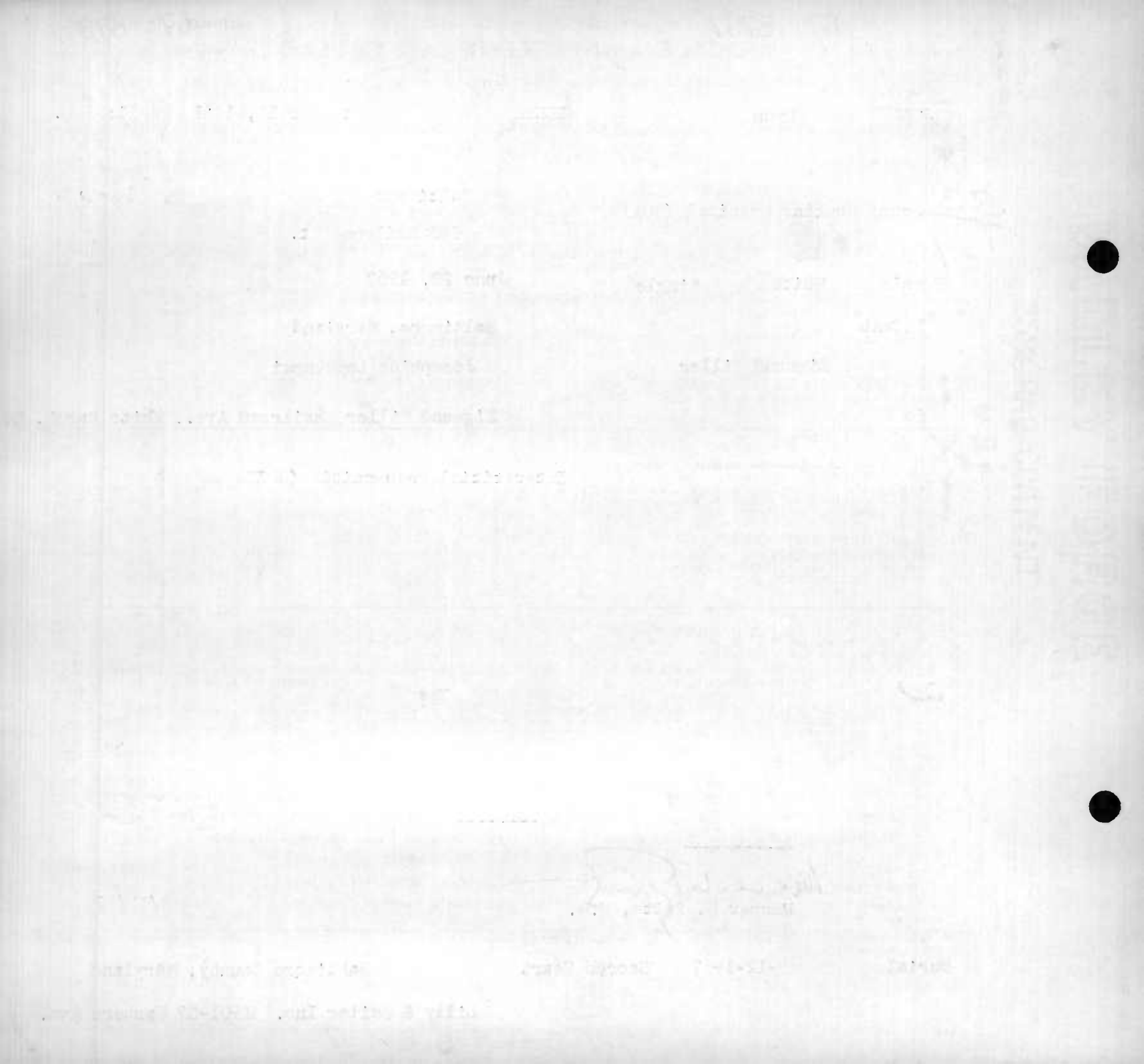
24B. NAME OF REGISTRAR

Robert E. Feltz

24C. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc. 1901-07 Eastern Ave.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLINTON WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1967 5:37 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1012 N. Vincent Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1008 Vincent Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

5/4/1923

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Passaic N.J.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Williams

14. MOTHER'S MAIDEN NAME

Lucy Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1945

16. SOCIAL
SECURITY NO.

141-14-7407

17. INFORMANT

Regina Turner

ADDRESS

1008 N. Vincent St.

18.

E983X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Contusion of heart

(A).....
DUE TO(B).....
DUE TO

(C).....

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Lot

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1012 N. Vincent Street

21D. TIME
OF INJURY
(APPROX.)

?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subject collapsed during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-18-67

23C. NAME OF CEMETERY or CREMATORY

BA/Lo; NAT.

23D. LOCATION

Ba/Lo

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

MORTON & Pyett

ADDRESS

1701 LAURENS

100

100

100

100

100

100

100

100

100

100

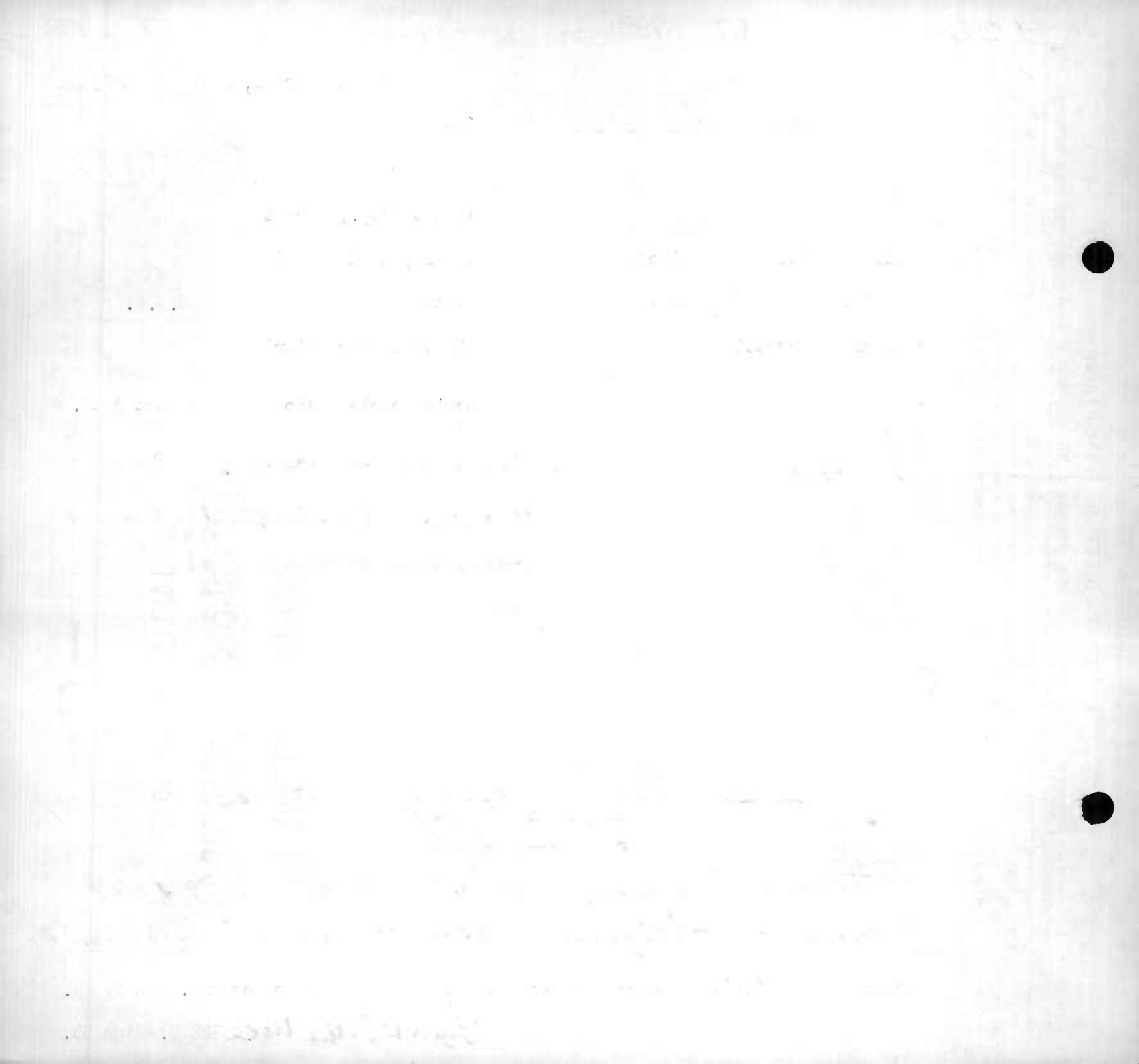
100

100

100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8799				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8799			
1. NAME OF DECEASED (Type or Print) ROSE MILIO				2. DATE AND HOUR OF DEATH September 12, 1967 1:35 a.m.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 12-01 4 East 39th., Street							
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Aug 28, 1901		9. AGE (In years last birthday) 66		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francesco Pirrotti				14. MOTHER'S MAIDEN NAME Giuseppa Giardinieri							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Louis Romolo Milio (SON)				ADDRESS 4 East 39th.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 199.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Carcinoma - left hand - DUE TO Metastasis (wide-spread) - 6 months (B) Secondary Anemia DUE TO (C) Secondary Anemia				INTERVAL BETWEEN ONSET AND DEATH 8 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from April 27 1967 to Sept 12 1967, that (I) (we) last saw the deceased alive on Sept. 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Philibert Artigiani M.D.				23B. DATE SIGNED 9/13/67							
23C. PHYSICIAN'S NAME (Type) Philibert Artigiani M.D.				23D. ADDRESS 2305 Mayfield Ave - Baltimore, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/67		24C. NAME of CEMETERY or CREMATORY Lorraine Park Mausoleum		24D. LOCATION (City, town, or county) (State) 5608 Dogwood Rd. Balto, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR R. B. E. E. E.		25C. FUNERAL DIRECTOR Young & Sons		ADDRESS 322 S. High St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8800		67 8800		67 8800	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		MRS Lucy LEE		14 Sept 1967 4:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
35 Church Home & Hospital		Md.			
CERTIFICATE AMENDED 9-22-67		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		913 E BALTIMORE ST		S. Carrollton	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify))	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
F	ORIENTAL	WIDOWED	7-9-1990	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		Laundry		China	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Louie Hok Zie		Toy SEE		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT; SON	
NO		212-46-7957		THOMAS LEE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) GASTRIC CARCINOMA			
ANTECEDENT CAUSES		(B) METASTATIC DISEASE TO LIVER			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ANEMIA			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 6 19 67 to September 14 19 67, that (I) (we) lost saw the deceased alive on September 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Corazon Z. Vergara MD				September 14 '67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
CORAZON Z. VERGARA				CHURCH HOME'S HOSPITAL 100 N. BROADWAY BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Sept 18/67		Lanark	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 14 1967		E. E. E. E. E.		Stewart Thomas Co - 108 W North	

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

J.
EDWARD ZAMARA

2. DATE AND HOUR PRONOUNCED DEAD

September 13, 1967 7:05 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4617 Asbury Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

July 25, 1921

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

D.C.A. CORPORATION

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

JOHN ZAMARA

14. MOTHER'S MAIDEN NAME

ROSE KOLTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ROSE ZAMARA 4617 ASBURY AVE

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/16/67

23C. NAME OF CEMETERY or CREMATORY

HOLY ROSARY CEMETERY

23D. LOCATION

(City, town, or county)

(State)

GERMAN HILL RD. DUNDALK

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1967

24B. NAME OF REGISTRAR

John E. Fisher

24C. FUNERAL DIRECTOR

JOHN M. WEBER AND SONS INC.

ADDRESS

401 CHESTER ST

26/04/01

VALLEY FORD

VALLEY FORD

20/04/01

1

10/04/01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8802	
BIRTH NO. 67 8802		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LAWSON COOPER		2. DATE AND HOUR OF DEATH 9/13/67 11:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSP.		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO	
		D. STREET ADDRESS (If rural, give location) 1228 Mosher St.			
5. SEX M	6. RACE N C	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/25/12	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER		10B. KIND OF BUSINESS OR INDUSTRY FURNITURE		11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH			14. MOTHER'S MAIDEN NAME JOSEPHINE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT RECORDS
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Intracranial hemorrhage - 24 hours ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension, etiology (?)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/13 19 67 to 9/13 19 67 that (I) (we) last saw the deceased alive on 9/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hector L. Feliciano M.O.				23B. DATE SIGNED 9/13/67	
23C. PHYSICIAN'S NAME (Type) HECTOR L. FELICIANO M.D.				23D. ADDRESS FRANKLIN SQ. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-17-67		24C. NAME OF CEMETERY OR CREMATORY Pleasant Shade	
24D. LOCATION (City, town, or county) (State) Newport News VA		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR MORTON J Dyer	
25C. FUNERAL DIRECTOR 1701 LAURENS		25D. ADDRESS			

Furnitures

Price of Plant & Stock
Horse - 2000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8803	
CERTIFICATE OF DEATH					
BIRTH NO. 67 8803					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Luis Suarez (Louis Manuel Suarez)		2. DATE AND HOUR OF DEATH 9-13-67 3:00 pm M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE UNIVERSITY OF MARYLAND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY City of Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1327 Hollins St.			
5. SEX M	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 6-21-12	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Brush Fiber		11. BIRTHPLACE (State or foreign country) Puerto Rico	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Julian Suarez			
14. MOTHER'S MAIDEN NAME Carmen Bariva		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 581-07-8227		17. INFORMANT ADDRESS Mrs. Carmin Diaz, 3012 W. Rogers Ave.			
18. 540.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Sepsis 20 to Peritonitis DUE TO (B) Peritonitis DUE TO (C) PERFORATED Gastric Ulcer		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 9-7-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED GASTRIC ULCER		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-3-1967 to 9-13-1967 , that (I) (we) last saw the deceased alive on 9-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael S. Weinstock		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-13-67	
23C. PHYSICIAN'S NAME (Type) Michael S. Weinstock		23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/1967		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) Pikesville, Balto. Co. Md.		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		25B. NAME OF REGISTRAR P. J. E. Johnson		25C. FUNERAL DIRECTOR ADDRESS 4611 Park Heights Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-220		67 8804		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8804	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BERTHA M. TSAGATOS		September 21, 1967. 9 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
44 Union Memorial Hospital				Md.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 21213 6-01			
				D. STREET ADDRESS (If rural, give location)			
				162 N. Decker Street Ave.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		Married		May 21, 1893.	
9. AGE (In years lost birthday)		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
74		74		Delaware		USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Homemaker							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Samuel M. Tull				Florence Disharron			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		None		Mr. Steve Tsagatos		(Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, etc. It means the disease, injury or complication which caused death.)				(A) PULMONARY EDMA			
ANTECEDENT CAUSES				(B) ARTERIOSCLEROTIC HEART DISEASE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from 3/25/62 to 9/13/67 that (I) last saw the deceased alive on 9/13/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
STUART D. SUNDAY						9/19/67	
23C. PHYSICIAN NAME (Type)				23D. ADDRESS			
STUART D. SUNDAY				201 W. 33rd St. (18)			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/16/67		Parkwood Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 14 1967		Robert E. Sisk		Leonard J. Ruck, Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

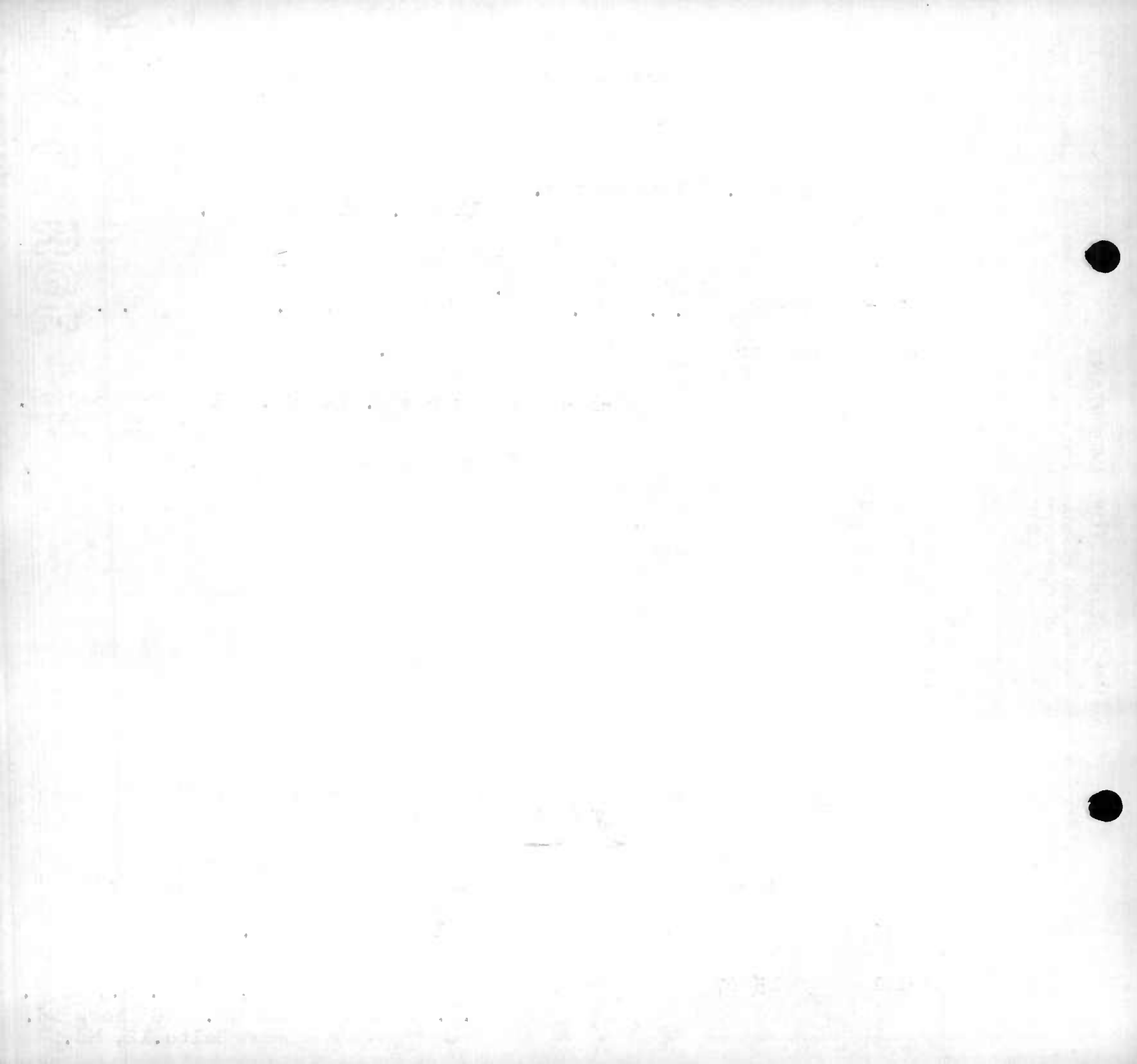
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8805		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8805	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR. OTTO MARKIN		2. DATE AND HOUR OF DEATH 9-12-67 18:37 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-10	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		D. STREET ADDRESS (If rural, give location) 10 N. CLINTON ST 21224			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Feb. 22-00	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PLUMBER		10B. KIND OF BUSINESS OR INDUSTRY POLICE OFFICE		11. BIRTHPLACE (State or foreign country) LINTON, INDIANA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME EBENEZER MARKIN		14. MOTHER'S MAIDEN NAME FLORA WALTERS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES WWI	
16. SOCIAL SECURITY NO. 212-30-8175		17. INFORMANT BCH. RECORDS 4940 EASTERN AVENUE 21224 WIFE + SON (MR. WILLIAM O. MARKIN)		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) PULMONARY EDEMA DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 Hr 23 MIN 6 Hr 37 MIN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. POSSIBLE MYOCARDIAL INFARCT.					
19A. DATE OF OPERATION 25		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5:45 AM 9-12 19 67 to 8:37 AM 9-12 19 67, that (I) (we) last saw the deceased alive on 9-12 19 67 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Cordes		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-12-67	
23C. PHYSICIAN'S NAME (Type) DR. ROBERT A. CORDES ROBERT A. CORDES M.D.		23D. ADDRESS 4940 EASTERN AVENUE BALTIMORE CITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 14 1967		24F. NAME OF REGISTRAR Robert A. Cordes	
24G. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		24H. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 8806		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8806	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edward Albert Bloberger		2. DATE AND HOUR OF DEATH 9/12/1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-38 D. STREET ADDRESS (If rural, give location) 1124 E. Belvedere Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/24/1894	9. AGE (In years lost birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Inspector
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John Bloberger	
14. MOTHER'S MAIDEN NAME Meta M. Pestrup		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-38-2599	
17. INFORMANT George V. Imhoff, 5812 Northwood Dr.		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163 X I		(A) DUE TO Carcinoma of lung		March 1967	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		8 months	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 19 67 to 9/12 19 67 , that (I) (we) last saw the deceased alive on 8/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sol Smith		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/14/67	
23C. PHYSICIAN'S NAME (Type) Sol		23D. ADDRESS 1261 Belvedere Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/67		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) Parkville, Balto. Co., Md.		24E. STATE Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT											
V-422 67 8807 CERTIFICATE OF DEATH											
Registered No. 67 8807											
1. NAME OF DECEASED (Type or Print) GEORGE VLASES JR.						2. DATE AND HOUR OF DEATH 9/11/67 8:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY King George C. CITY OR TOWN (If outside city limits, write RURAL and give township) New Carrollton D. STREET ADDRESS (If rural, give location) 6104 86th Ave.					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 8/12/03		9. AGE (In years lost birthday) 64		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist				10B. KIND OF BUSINESS OR INDUSTRY Chemistry		11. BIRTHPLACE (State or foreign country) St. Louis Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Vlases Sr.						14. MOTHER'S MAIDEN NAME Jeanette Charpentier					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 216-44-3707		17. INFORMANT Mrs. Helen G. Vlases New Carrollton, Md					
18. I 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Uremia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Nephrolithiasis						CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. History of congestive heart failure											
19A. DATE OF OPERATION several operations				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of the bladder		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9/5/67 19 to 9/11/67 19 67, that (I) (we) last saw the deceased alive on 9/11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Ovidio E. Vitas M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9/11/67		
23C. PHYSICIAN'S NAME (Type) Ovidio E. Vitas M.D.						23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery			24D. LOCATION (City, town, or county) (State) Woodlawn Balto Co Md.				
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967				25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Loring Byers		ADDRESS 8728 Liberty Rd Randallstown Md			

James Thompson

James Thompson

FUNERAL DIRECTOR: IMPORTANT

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D-120 BIRTH NO.		67 8808		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8808	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
				Charles J. Davis			
2. DATE AND HOUR OF DEATH				Sept 13 1967 8 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)				Md.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore 23-43			
D. STREET ADDRESS (If rural, give location)				2413 Herkimer St.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		white		married		10/9/1926	
9. AGE (In years lost birthday)		40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
				factor Brewer machinery Co.		Va.	
12. CITIZEN OF WHAT COUNTRY?		U. S. A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Calmadge Davis				Grace Hawk			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
N. W. # Navy				220-243572		Mrs Lorraine Davis	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Carcinoma descending colon			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
				2 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
July 1967		Ca of intestine		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 5-17 1966 to 9-13 1967, that (I) (we) last saw the deceased alive on 9/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
John P. Urlock Jr.						9/13/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN P. URLOCK JR.				1227 Washington Blvd			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/15/67		Baltimore National Cem		5501 Frederick Ave Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
SEP 14 1967		Robert E. Fairbank		John J. Gowan & Son Inc. 23, Md.			

Letter of 10/13/1936

10/13/1936

Dear Mr. [illegible]

2413 Washington St.

10/13/1936 40

W. H. [illegible]

Thank you for [illegible]

Very truly yours [illegible]

2413 Washington St.

10/13/1936 40

Dear Mr. [illegible]

Thank you for [illegible]

Very truly yours [illegible]

10

10/13/1936 40
W. H. [illegible]
2413 Washington St.

BIRTH NO.		M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
W-460		67 8809		BALTIMORE CITY HEALTH DEPARTMENT		67 8809	
1. NAME OF DECEASED (Type or Print) VIDOLE M. WALLER				2. DATE AND HOUR PRONOUNCED DEAD September 11, 1967 1:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Dundalk 53-00 D. STREET ADDRESS (If rural, give location) 7940 St. Bridgett Lane			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH Oct. 27, 1923	9. AGE (In years last birthday) 43	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10B. KIND OF BUSINESS OR INDUSTRY Bunny's Drive In		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alex Wigner				14. MOTHER'S MAIDEN NAME Fredonia Wince			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 233-32-5458		17. INFORMANT Mrs. Nancy Lambros, 5147 Darien Rd. Balto. Md. ADDRESS 21206			
18. E 819.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Batavia Farm Road 53-00			
21D. TIME OF INJURY (APPROX.) 9/6/67 4:45 P. M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subj. operator of car - went out of control and struck building.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/12/67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9/14/67		23C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. SEP 14 1967		24B. NAME OF REGISTRAR John J. Duda		24C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			

LETTER BOXES

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 0-416 67 8810					CERTIFICATE OF DEATH						
M.E. CASE NO.					Registered No. 67 8810						
1. NAME OF DECEASED (Type or Print) Carroll W. Oliver					2. DATE AND HOUR OF DEATH Sept. 11, 1967 11 30 P. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224					A. STATE MARYLAND B. COUNTY BALTIMORE Co.						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 33-00						
					D. STREET ADDRESS (If rural, give location) 824 MILDRED AVENUE - 21222						
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 2/7/25	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Bendix Corp.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CHARLES OLIVER					14. MOTHER'S MAIDEN NAME AMELIA Ullmann						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII			16. SOCIAL SECURITY NO. 218-18-4193		17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224						
18. 200.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RETICULUM CELL SARCOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) RETICULUM CELL SARCOMA DUE TO (B) DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH 6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (This hospital) attended the deceased from 9-7 19 67 to 9-11 19 67 , that (1) (we) last saw the deceased alive on 9-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Ross T. Krueger					M.D. Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Stall Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9-11-67			
23C. PHYSICIAN'S NAME (Type) Ross T. Krueger					23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/67		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.					

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67 8811 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8811

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THERESA

M.

OHMSTEDE

2. DATE AND HOUR PRONOUNCED DEAD

September 10, 1967

11:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

5921 Cedonia Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5921 Cedonia Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

October 18, 1900

9. AGE (In years
last birthday)

67.66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

Dorchester Co., Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY METZ

14. MOTHER'S MAIDEN NAME

CATHERINE KALMPS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

214-10-82548

17. INFORMANT

George E. Ohmstede

ADDRESS

SAME

18.

353.3 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Death During Epileptic Seizure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Meningioma of right post fossa

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9-14-1967

23C. NAME of CEMETERY or CREMATORY

Parkwood

23D. LOCATION

(City, town, or county)

(State)

Towson, BALTO., MD

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 15 1967

J. J. E. Johnson

J. Valters 5444 BELAIR Rd.

James L. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8812		CERTIFICATE OF DEATH		67 8812	
M.E. CASE NO.			2		
1. NAME OF DECEASED (Type or Print) GEORGE EDWARD SCHISLER			2. DATE AND HOUR OF DEATH 9/12/67 3:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL Hospital			A. STATE MARYLAND B. COUNTY BALTO Co		
If not in hospital or institution, give street address or location			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore (Rural) 21207		
			D. STREET ADDRESS (If rural, give location) 2813 N. Rolling Rd. 53-00		
5. SEX Male	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 9/10/1880	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - Retired		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Schisler		14. MOTHER'S MAIDEN NAME CATHERINE SUBOCK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-36-6733		17. INFORMANT ADDRESS Melvin E. Schisler 2721 N. Rolling Rd	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) MILD CEREBRAL ARTERY THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH WKS.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) GENERALIZED ASCUD YEARS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 9/29/67 19 67 to 9/12 19 67 , that (I) (we) last saw the deceased alive on 9/11 19 67 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles F. DeFilin M.D.				23B. DATE SIGNED 9/12/67	
23C. PHYSICIAN'S NAME (Type) CHARLES F. DEFILIN M.D.				23D. ADDRESS Md General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/67		24C. NAME OF CEMETERY or CREMATORY mt. Olive	
24D. LOCATION (City, town, or county) (State) Randallstown Md		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Spring Byers 8728 Liberty Rd Randallstown Md			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8813	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 8813 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) DOROTHY T. WOODWARD			2. DATE AND HOUR OF DEATH 9/12/67 1 745 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA B. COUNTY Nansemond C. CITY OR TOWN (If outside city limits, write RURAL and give township) SUFFOLK D. STREET ADDRESS (If rural, give location) 804 DUMVILLE AVEUNE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-30-17	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME GEORGE WALLS		
14. MOTHER'S MAIDEN NAME NELLIE T.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 231-44-6548			17. INFORMANT ADDRESS .Jacob L. Woodward (SPOUSE) Suffolk, Va.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RETICULUM CELL SARCOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 30 1967 to September 12 1967, that (I) (we) last saw the deceased alive on September 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John T. Flaherty				23B. DATE SIGNED September 12, 1967	
23C. PHYSICIAN'S NAME (Type) JOHN T. FLAHERTY				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-67		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Suffolk, Va.		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8814	
BIRTH NO. 67 8814				CERTIFICATE OF DEATH	
M.E. CASE NO.				11: A.M.	
1. NAME OF DECEASED (Type or Print) WEDDINGTON, Baby Girl (Rose)				2. DATE AND HOUR OF DEATH 9/6/67 11 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 2607 Robb Street 21218				9-07	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 9-5-67	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Howard Weddington			14. MOTHER'S MAIDEN NAME Rose Moore		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Records: BCH			4940 Eastern Avenue Baltimore, Maryland 21224		
18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Respiratory Failure DUE TO (B) Immaturity DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-5 19 67 to 9-6 19 67, that (I) (we) last saw the deceased alive on 9-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John E. O'Malley				23B. DATE SIGNED 9-6-67	
23C. PHYSICIAN'S NAME (Type) John E. O'Malley				23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 9/8/1967		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals	
24D. LOCATION Baltimore, Maryland		24E. NAME of CEMETERY or CREMATORY		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	
ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-17766 67 8815				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8815 7	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BOY COBB				2. DATE AND HOUR OF DEATH 9:10 8/26/67 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
44 Union Mem Hosp.				UNION MEM HOSP. MARYLAND			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALT. MD. 27-102			
D. STREET ADDRESS (If rural, give location)				3-3-3 709 BEAUMONT AVE.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH AUG 26-67	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	14
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				BALT.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
				RACHEL COBB			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. 776X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO PREMATUREITY		INTERVAL BETWEEN ONSET AND DEATH 14 HRS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from AUG 26 19 67 to AUG 26 19 67, that (I) (we) lost saw the deceased olive on AUG 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. H. Greenberg				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED AUG 26/67	
23C. PHYSICIAN'S NAME (Type) A. H. GREENBERG		M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
				ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/31/67		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
						UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8816		67 8816		67 8816	
1. NAME OF DECEASED (Type or Print) CHARLES L. MURPHY			2. DATE AND HOUR OF DEATH 9-4-67 2:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 1809 ST. PAUL ST.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) ?	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ?		
14. MOTHER'S MAIDEN NAME ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		
16. SOCIAL SECURITY NO. ?			17. INFORMANT None		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) acute pulmonary edema associated with septicemia dehydration starvation			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from 9-3 1967 to 9-4 1967 , that (I) we last saw the deceased alive on 9-4 1967 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE Frank Palmisano M.D.				23B. DATE SIGNED 9-4-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/7/67		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. LOCATION (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

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Frank Robinson

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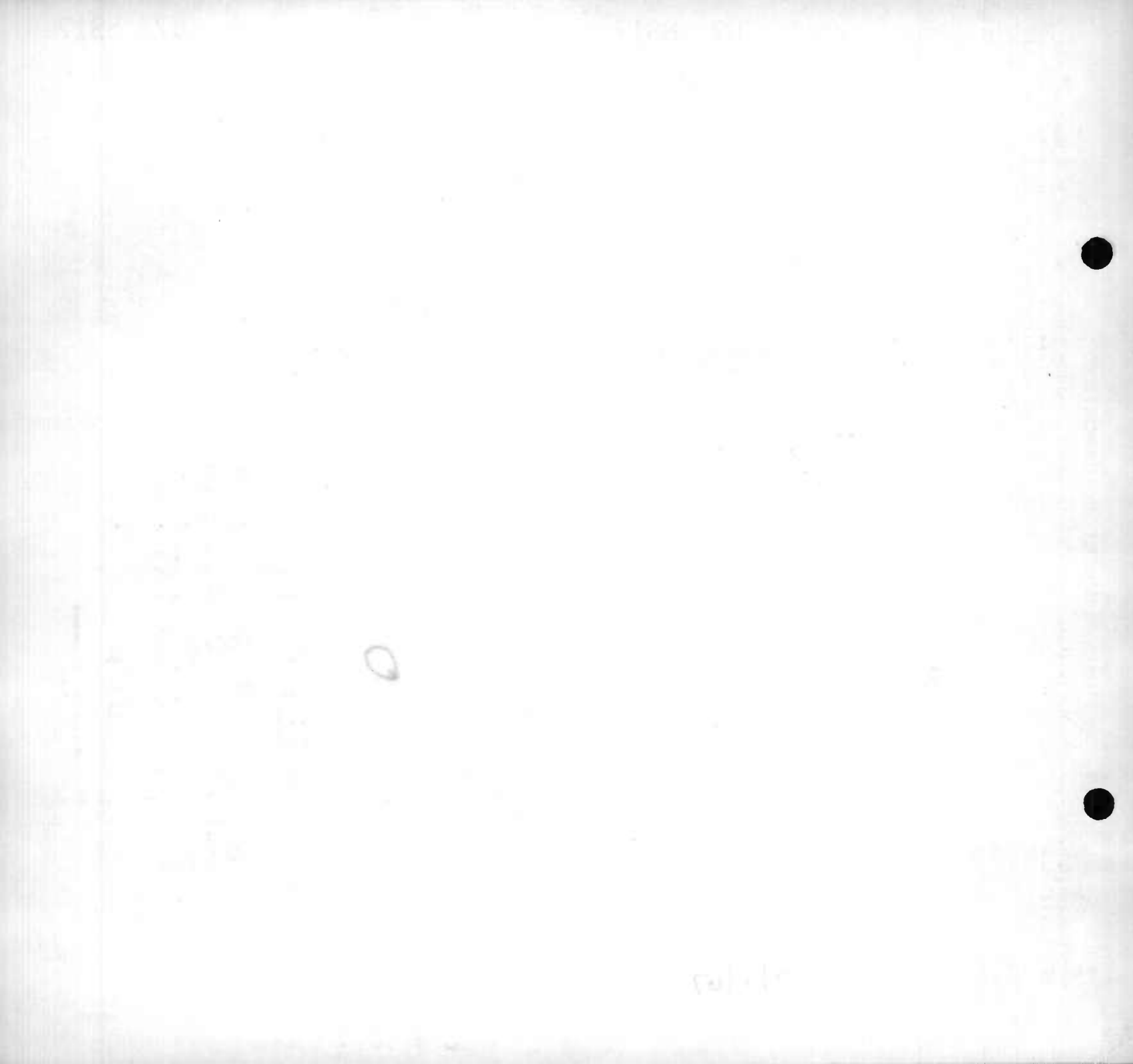
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <u>67-20209</u>		<u>67</u> <u>8817</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>Baby Boy Toney</u>		<u>8/27/67</u> <u>1</u> <u>245</u> <u>A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>Sinai Hosp. of Baltimore</u>			
C. CITY OR TOWN (If outside city limits write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
<u>42</u>		<u>Baltimore, Md.</u> <u>15-10</u> <u>3830 BOARMAN AVE.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8/26/67</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
					<u>6</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>None</u>		<u>New Born</u>		<u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Leon Toney</u>			14. MOTHER'S MAIDEN NAME <u>CARTER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					<u>Hosp Chart</u>
18. <u>761.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Pulmonary insufficiency</u> DUE TO			
		(B) <u>Prematurity 25 weeks gestation</u> DUE TO			
		(C) <u>Abruptio Placentae</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>None</u>		<u>None</u>		<u>None</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<u>None</u>		<u>None</u>		<u>None</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Home <input checked="" type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
<u>None</u>				<u>None</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8:00 PM 8/26/67</u> to <u>2:45 AM 8/27/67</u> , that (I) (we) last saw the deceased alive on <u>8/27/67</u> at <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frank Bouyer</u>				23B. DATE SIGNED <u>8/27/67</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/1/67</u>		24C. NAME of CEMETERY or CREMATORY	
				<u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>SEP 15 1967</u>		<u>Dr. J. E. Tashman</u>		<u>MORTUARY SERVICE</u>	
				ADDRESS <u>RCMD</u>	



W-452

67 8818

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8818

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JAMES WILLIAMS 2. DATE AND HOUR PRONOUNCED DEAD August 17, 1967 7:42 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 10-03 D. STREET ADDRESS (If rural, give location) Maryland Penitentiary

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH 9. AGE (In years (last birthday)) 40 If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry [] Inspection [] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner [] ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER [] DATE SIGNED August 17, 1967 EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER []

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 9/11/67 23C. NAME OF CEMETERY or CREMATORY 23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR 24D. ADDRESS HOSPITAL DISPOSAL

1 9 5 7 0 0 0 8 8 3 0

WILLIAM H. HARRIS

9/1/03

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-17723</u> <u>67</u> <u>8819</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67</u> <u>8819</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH <u>Sept 5/67</u> <u>18</u> ¹⁰ <u>A</u> M.	
1. NAME OF DECEASED <u>Darnell Baby Boy Robinson</u>		2. DATE AND HOUR OF DEATH			
(Type or Print)					
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hosp</u>		A. STATE <u>Baltimore</u> B. COUNTY <u>20-02</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2501 Edmondson Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>8/30/67</u>	9. AGE (In years last birthday) <u>2</u>	If Under 1 Yr. Months: <u>2</u> Days: <u>6</u> Hours: <u>—</u> Min. <u>—</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>	
13. FATHER'S NAME <u>Leroy Harry Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Odella Brown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hosp. chart</u>	
				ADDRESS	
18. <u>570.51</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <u>Jejunal perforation</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) <u>—</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) <u>—</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Prematurity (2 lb - 11 oz)</u>		<u>6 Day</u>	
19A. DATE OF OPERATION <u>9/4/67</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Small obstruction</u>	20A. AUTOPSY? (Yes or No) <u>YES</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 3</u> 19 <u>67</u> to <u>Sept 5</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 5</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Franklin L. Johnson</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>Sept 5, 1967</u>		
23C. PHYSICIAN'S NAME (Type) <u>Franklin L. Johnson</u>		M.D.	23D. ADDRESS <u>UNIVERSITY MEDICAL SCHOOL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>—</u>	24B. DATE <u>9/13/67</u>	24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1967</u>		25B. NAME OF REGISTRAR <u>Robert S. Farber</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	
				ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8820</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66-28047 67 8820</u> CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Vernor Sanford Brown</u>			2. DATE AND HOUR OF DEATH <u>8/23/67</u> <u>13⁰⁰</u> <u>A</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hosp.</u>			A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>			D. STREET ADDRESS (If rural, give location) <u>1829 Kavanagh St.</u>		
5. SEX <u>m</u>	6. RACE <u>N C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>12/29/64</u>	9. AGE (In years lost birthday) <u>2</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Fraderick Brown</u>			14. MOTHER'S MAIDEN NAME <u>Verna Brown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Hosp. Chart</u>		
18. <u>357X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Cushing's ulcers of Dunderman (2)</u> DUE TO (B) <u>Stress</u> DUE TO (C) <u>Cerebral palsy, severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>48 hrs.</u> <u>since birth</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>8/21</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>incarcerated @ hernia</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 19</u> <u>1967</u> to <u>Aug 23</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 23</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Franklin L. Johnson</u>				23B. DATE SIGNED <u>8/23/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Franklin L. Johnson</u>		23D. ADDRESS <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>9/13/67</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>	
24D. LOCATION <u>HOSPITAL DISPOSAL</u>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <u>SEP 15 1967</u>	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR <u>08070</u>	

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67 8821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 8821

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		EARL SCHULTZ		4 SEPT. 1967 5:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
37 Mercy Hospital		BALTIMORE		4-01	
D. STREET ADDRESS (If rural, give location)		125 CHEAPSIDE AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	CAUC		16 NOV. 09	58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
381.1 I		ESOPHAGEAL VARICES		24 HRS	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) UNDETERMINED DUE TO			
ANTECEDENT CAUSES		(B) LAENNEC CIRRHOSIS DUE TO		YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(C) CHRONIC ALCOHOLISM		YEARS	
II		CARONIC MALNUTRITION		YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
				(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 28 AUG. 1967 to 4 SEPT 1967, that (1) (we) last saw the deceased alive on 4 SEPT 19 67 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did nat) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William A. Dear				4 Sept. 67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
		9/12/67		ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 15 1967		Robert E. Talbot		UNIVERSITY MEDICAL SCHOOL	
				MORTUARY SERVICE - BCHO	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-18344		67 8822		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8822	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or print) <i>Douglas Lee Shirley</i>				9/9/67 4 40 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>				A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Dundalk</i> <i>21222</i>			
				D. STREET ADDRESS (If rural, give location) <i>7456 School Ave</i> <i>53-00</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>9/7/67</i>	9. AGE (In years last birthday) <i>2</i>	If Under 1 Yr. Months <i>2</i>	If Under 24 Hrs. Days <i>2</i>	If Under 24 Hrs. Hours <i>40</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Gary Orvach</i>				14. MOTHER'S MAIDEN NAME <i>Dawn Shirley</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mother</i>		ADDRESS	
18. <i>763.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Respiratory Failure</i>				CAUSE OF DEATH (A) DUE TO <i>Respiratory Failure</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Respiratory Failure</i>				(B) DUE TO <i>Kyoline Munhane +</i>			
				(C) <i>Respiratory Failure</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>9-9-67</i>		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>9-7-67</i> to <i>9-9-67</i> that (1) (we) last saw the deceased alive on <i>9-9-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Virgilio G. Javier</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-9-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Virgilio G. JAVIER</i> M.D.				23D. ADDRESS <i>Maryland General Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>9/13/67</i>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>MORTUARY SERVICE - BCHD</i>			

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67 8823 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8823

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES

M.

FRENCH Sr.

2. DATE AND HOUR PRONOUNCED DEAD

September 13, 1967 5:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

825 W. Lombard St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

3/14/1902

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Motion Picture Projector Ford Motor Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles R. French

14. MOTHER'S MAIDEN NAME

Annie Widman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; if yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-07-1221

17. INFORMANT

Mrs Mary French

ADDRESS

above

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/14/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/18/67

23C. NAME of CEMETERY or CREMATORY

London Park Cem.

23D. LOCATION (City, town, or county)

3801 Frederick Ave

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John J. Cowan & Son Inc.

ADDRESS

901 St. Hollins

23. md. v

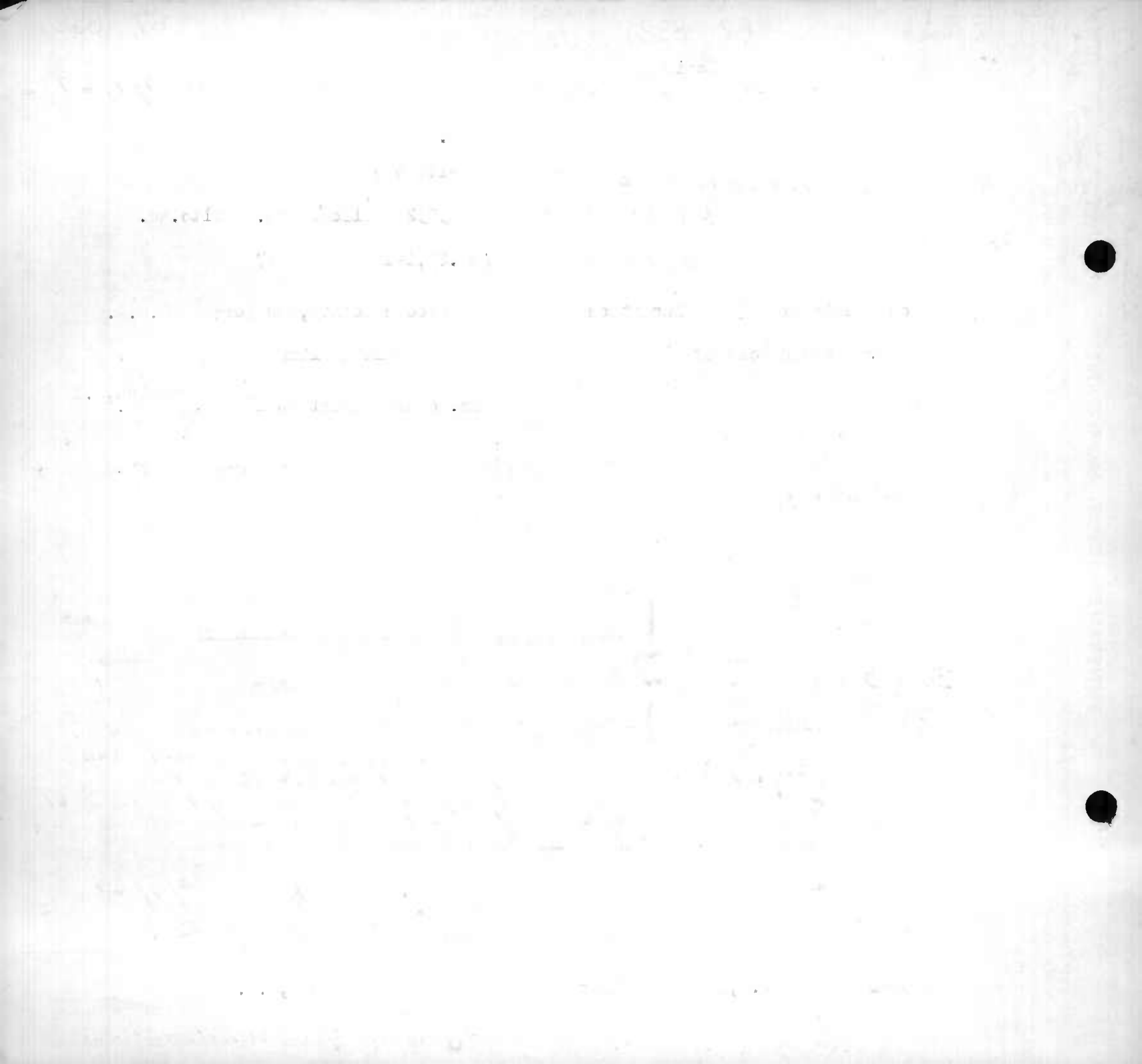
WALLACE
502 N. 3rd St.
ST. LOUIS, MO.

Medical Examiner's Office Release Body to the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

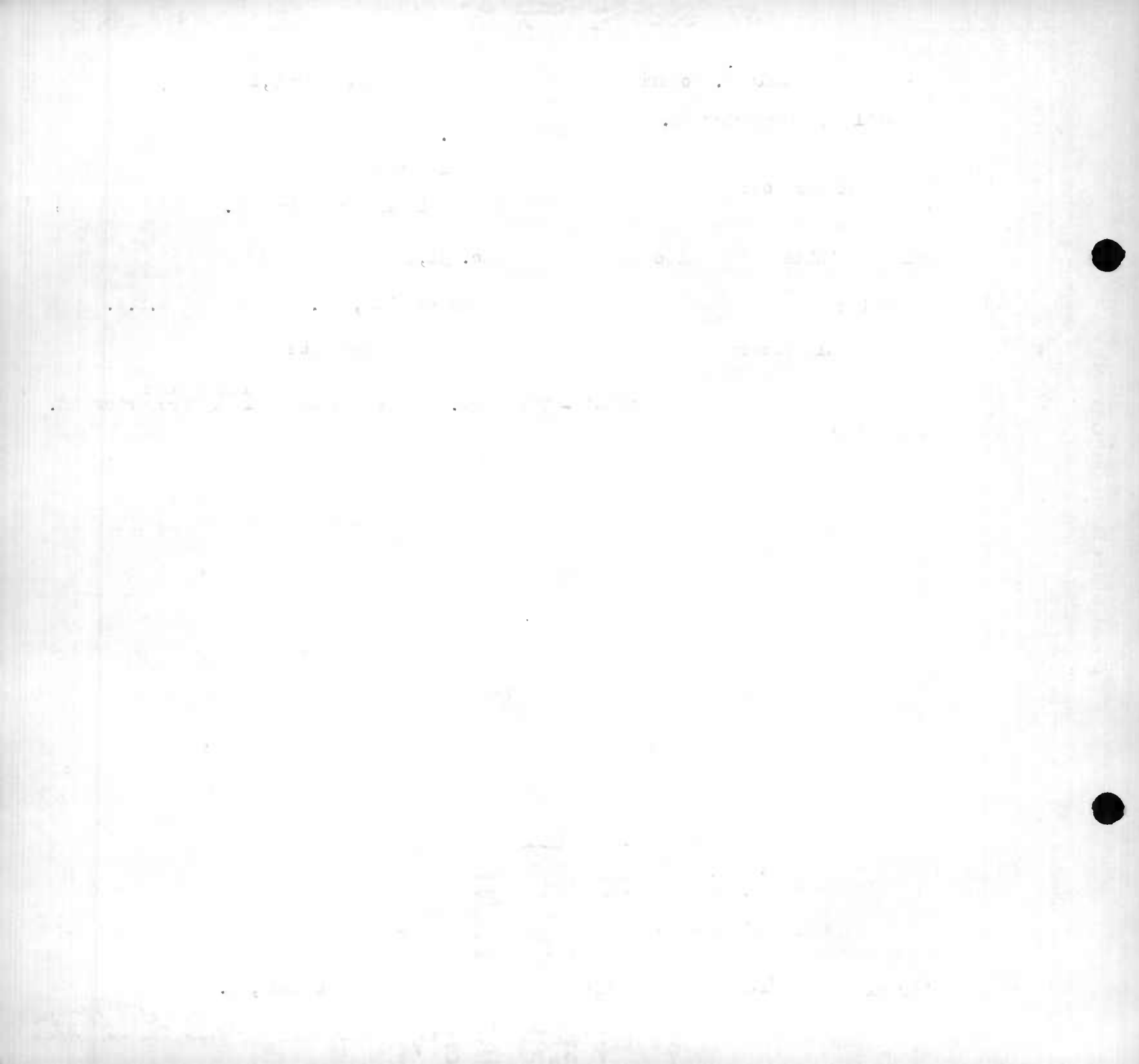
BIRTH NO. 360		67 8824		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8824	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) David Franklin Scudder			
2. DATE AND HOUR OF DEATH				1:45 A.M. 9/7/67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md.			
SINAI HOSPITAL OF BALTIMORE				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location)				3032 Guilford Ave. Balto. Md.			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED		8. DATE OF BIRTH Feb. 23, 1910	
9. AGE (In years lost birthday) 57		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Broome County, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Corbin Scudder		14. MOTHER'S MAIDEN NAME Nellie Fling		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Robert Christman 15 Newton Ave.		ADDRESS Noewich, N.Y.		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION	
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost.) ASCVD		20. INTERVAL BETWEEN ONSET AND DEATH 4 days		21. CAUSE OF DEATH (A) DUE TO MYOCARDIAL INFARCTION (B) DUE TO ASCVD (C) DUE TO		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. FRACTURE @ ANKLE, FOAM CAST	
23. DATE OF OPERATION 9/3/67		24. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE @ ankle		25. AUTOPSY? (Yes or No) YES		26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) (done)		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STAIRWAY IN HOME		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3032 GUILFORD AVE.		30. HOW DID INJURY OCCUR? WALKING DOWN STAIRS AND TWISTED @ ANKLE	
31. TIME OF INJURY (APPROX.) 8/31/67 2:30 PM		32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		33. I certify that (this hospital) attended the deceased from 9/3/67 to 9/7/67		34. and that in (my) opinion death occurred on the date 9/6/67	
35. and hour and from the causes stated above, (I) (did) (view) the body after death.		36. SIGNATURE Abe Levy		37. DATE SIGNED 9/7/67		38. PHYSICIAN'S NAME (Type) ABE LEVY	
39. ADDRESS M.D. Sinai Hospital		40. DATE BURIAL CREMATION, REMOVAL (Specify) Removal		41. DATE 24B. DATE Sept. 8, 1967		42. NAME OF CEMETERY or CREMATORY Windsor	
43. LOCATION Windsor, N.Y.		44. DATE REC'D BY HEALTH DEPT.		45. NAME OF REGISTRAR		46. FUNERAL DIRECTOR	
47. ADDRESS		48. DATE SEP 15 1967		49. NAME OF REGISTRAR		50. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

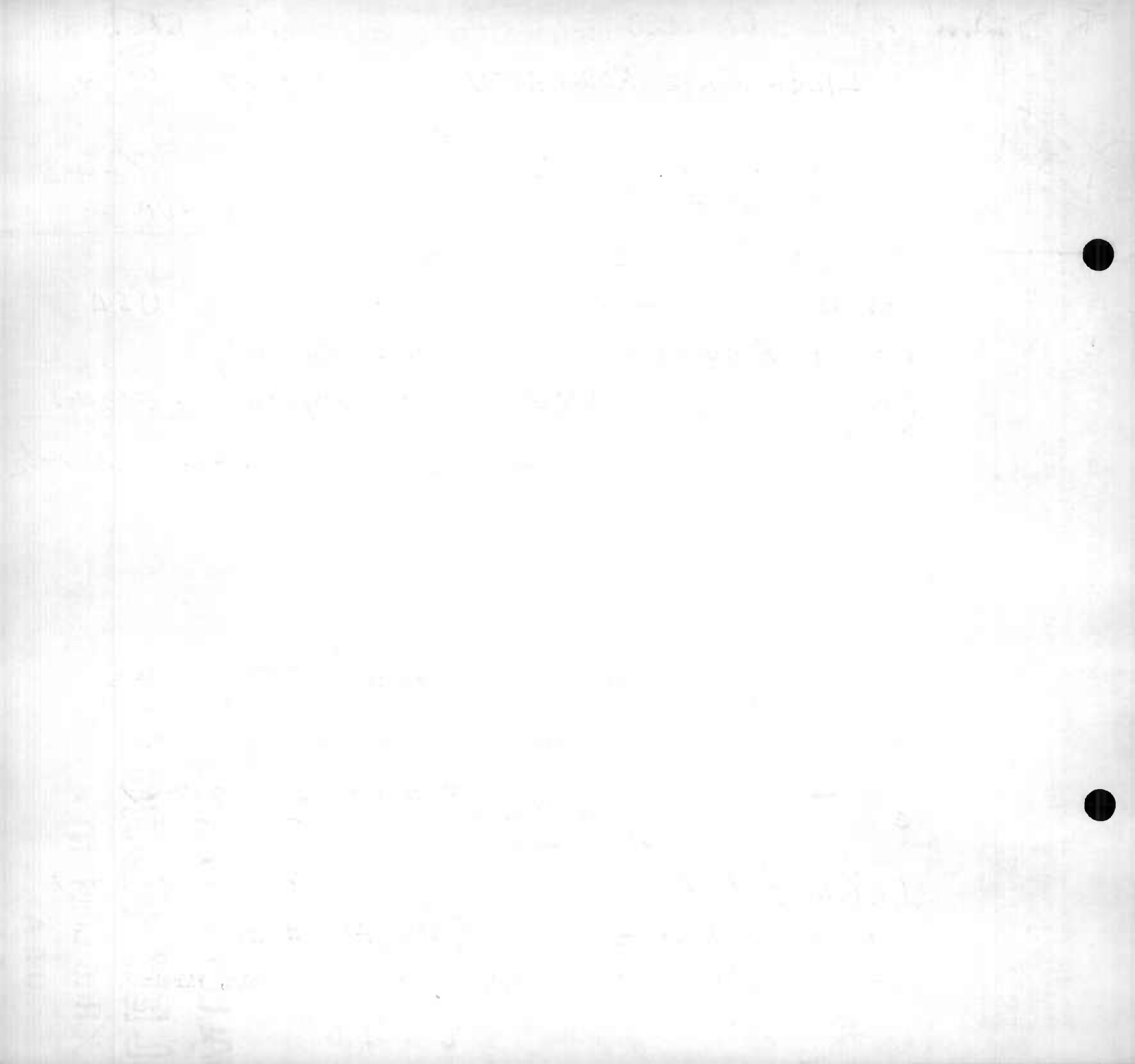
BIRTH NO. 67 8825		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8825	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Ella T. Rogers		
2. DATE AND HOUR OF DEATH September 7, 1967 2 ⁰⁰ p. m.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND 4501 Old Frederick Rd. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Uplands Home		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-04			
D. STREET ADDRESS (If rural, give location) 4501 Old Frederick Rd.					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec. 31, 1890	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Forest Hill, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Ely Tucker		
14. MOTHER'S MAIDEN NAME Sarah Roe			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 220-20-6707		17. INFORMANT ADDRESS Uplands Home Mrs. Idus Robertson 4501 Old Frederick Rd.			
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) arteriosclerotic vascular disease DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 10 days 1 yr +			19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 1966 to Sept 7 1967, that (I) (we) last saw the deceased alive on Sept 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John A Nesbitt Jr. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 9-9-67		
23C. PHYSICIAN'S NAME (Type) JOHN A NESBITT JR. M.D.			23D. ADDRESS 1009 Frederick Rd Baltimore Ind 21228		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME of CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967			
25B. NAME OF REGISTRAR Wm. F. 7		25C. FUNERAL DIRECTOR Wm. F. 7			
25D. ADDRESS Baltimore, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Virginia</i> 67 8826		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8826	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) LINDA GAYE RODGERSON			2. DATE AND HOUR OF DEATH 9/9/67 2:25 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VA. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 28 USPHS Hospital BALTIMORE, Md.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) NORFOLK		
			D. STREET ADDRESS (If rural, give location) 3711 GARFIELD AVE.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 8-5-62	9. AGE (In years lost birthday) 5	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VA.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Dewey A RodgerSON			14. MOTHER'S MAIDEN NAME DORA GulleDge		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS USPHS Hospital RECORD	
18. I 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Acute Lymphatic Leukemia DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH Months		
MEDICAL CERTIFICATION					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that my (this hospital) attended the deceased from 8-11-67 19 to 9-9-67 19, that we (we) last saw the deceased alive on 9-9-67 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. we (We) (did) did not view the body after death.					
23A. SIGNATURE William L Wilkie M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9-10-67	
23C. PHYSICIAN'S NAME (Type) William L WILKIE		23D. ADDRESS M.D. SAME AS #3			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 9/10/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Memorial Gardens	
				24D. LOCATION (City, town, or county) (State) Norfolk, Virginia	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert S. Jackson		25C. FUNERAL DIRECTOR ADDRESS William J. Jackson & Sons North Pa Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8827		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8827	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RAGLAND BESSIE		2. DATE AND HOUR OF DEATH 9-8-67 5:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 9-06 D. STREET ADDRESS (If rural, give location) 2832 HARFORD RD. Harford Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 06-31-90	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME HENRY NIEMANN			
14. MOTHER'S MAIDEN NAME EMMA SEBO		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Raymond T. Ragland as above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Myocardial INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 17 days			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-4-67 19 67 to 9-8-67 19 67 , that (I) (we) last saw the deceased alive on 9-8- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raul V. Desquitado		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-8-67	
23C. PHYSICIAN'S NAME (Type) RAUL V. DESQUITADO		23D. ADDRESS THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Myelung J. Dickner + Sons North + Pa ave	

BESSIE

MAR 21 1940

BALTIMORE

2722 HANCOCK ST.

04-21-40

UNION MEMORIAL HOSPITAL

HARRIS

F W

HOME

LOVE

HENRY NIEMANN

ELMA JEN

MAR 21 1940

0-2-40

0-2-40

0-2-40

THE UNION MEMORIAL HOSPITAL

WILLIAM T. STUART

ELMA V. DESIGNATED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8828</u>
BIRTH NO. <u>67 8828</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Pretty, George T.</u>		
2. DATE AND HOUR OF DEATH <u>9-13-67</u> <u>6.50</u> A.M.				
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles General Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Balto. Co.</u>		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
		D. STREET ADDRESS (If rural, give location) <u>1532 Gail Road Apt C</u>		
5. SEX <u>Male</u>	6. RACE <u>Wh.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>2-3-1897</u>	9. AGE (In years lost birthday) <u>70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Lever Bros.</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Pretty, Thomas</u>		
14. MOTHER'S MAIDEN NAME <u>, Mary</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>217-05-3458A</u>		17. INFORMANT <u>chart</u>		
18. <u>527.21</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>PULMONARY EMBOLISMS</u> DUE TO		
ANTECEDENT CAUSES		(B) <u>Intestinal OBSTRUCTION</u> DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Chronic LUNG DISEASE</u>		
INTERVAL BETWEEN ONSET AND DEATH <u>2 and 5 days</u>		<u>2 days</u>		
<u>15 years</u>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>8-23</u> 19 <u>67</u> to <u>9-13</u> 19 <u>67</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>9-13</u> 19 <u>67</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.				
23A. SIGNATURE <u>Juan F. Aleman</u>				23B. DATE SIGNED <u>9-13-67</u>
23C. PHYSICIAN'S NAME (Type) <u>A. Lewis Kolodny - attending</u>		23D. ADDRESS <u>1825 Eastern Blvd. 21221</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>SEPT 16 67</u>		24C. NAME OF CEMETERY or CREMATORY <u>SACRED HEART</u>
24D. LOCATION <u>BALTO.</u>		24E. (City, town, or county) <u>M.D.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Stachura</u>		25C. FUNERAL DIRECTOR <u>John J. Connelly Sons.</u>
25D. ADDRESS <u>300 mace ave.</u>				

PRINT SEP 14 1962

HEART

PLATE

Heart, frontal view

1
M-202

67 8829 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8829

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD

T.

MACIJCZYK-MACIEJCZYK

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1967

4:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

53-00

D. STREET ADDRESS (If rural, give location)

201 Antietam Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

MAY 15-1934

9. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

ALCOHOLIC CHEM. CO.

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

BENEDICT MACIEJCZYK

14. MOTHER'S MAIDEN NAME

ANNA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

235-52-2670

17. INFORMANT

EDNA MACIEJCZYK

ADDRESS

SAME AS

ABOVE

18.

E 81571

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Multiple Injuries

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, steel, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Eastern Blvd. & Riverside Road

53-00

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9/6/67 4:35 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subj. operator of
motorcycle - struck another car.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

SEPT. 15, 67

23C. NAME OF CEMETERY or CREMATORY

GARDENS OF FAITH

23D. LOCATION (City, town, or county)

BALTO.

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John J. Connelly Sons.

ADDRESS

300 Race Ave.

MARRIED MAY 12-1928
MECHANIC
BENEDICT MACIEJCZYK
ANNA
POLAND
235-2-3000 E. 11th Ave. S. E.
MINNAPOLIS, MINN.

BURIAL 227150 GARDENS OF FAITH BAPT.

John J. Connelley

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8830		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8830	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SARAH DOLLIE BURKETT		2. DATE AND HOUR OF DEATH SEPT. 12, 1967 11:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERN 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND		D. STREET ADDRESS (If rural, give location) BOX 118-A ROGERS LANE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-21-10	9. AGE (In years last birthday) 57 SEX	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH SHRADER		14. MOTHER'S MAIDEN NAME NELLIE ASBURY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT PATIENT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF THE OVARY WITH CHEST & ABDOMINAL METASTASIS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH KNOWN 9 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-13-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BOWEL OBSTRUCTION		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 10, 1967 to Sept 12, 1967. That (I) (we) lost saw the deceased alive on Sept 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Harrison		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept 12, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. UNIVERSITY OF MD. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 16/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park	
24D. LOCATION Glen Burnie, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR Singleton Funeral Home Glen Burnie, Md.	

BARBAR KATHLEEN BARKETT SENT 12 1967 11:25A

MR. ARNE ARNOLD
STREET
BOX 15 A ROGERS LAKE

UNIVERSITY OF MICHIGAN

2-21-68 21 XXXX

F W - 11-11-68

USA

HOUSING HOUSING

WELLS AGENCY

JOSEPH CHADLER

PATIENT

NO

ALBANY, ALBANY OF KNOW
THEY ARE WITH
CHADLER AGENCY
MICHIGAN

2-21-68 21 XXXX

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UNIVERSITY OF MICHIGAN

CHADLER AGENCY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8831		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8831	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN BONASZEWSKI <i>Bonaszewski, Mr John</i>		2. DATE AND HOUR OF DEATH 9-13-67 at 3 am	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 8-10-1897		9. AGE (In years lost birthday) 70 71		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER Laborer Food Packing		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN BONASZEWSKI		14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 213 16 6856		17. INFORMANT MARIE BLOTENBERGER		ADDRESS 3816 BROOKLYN AVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA DUE TO CARCINOMA OF LIVER DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-8-1967 to 9-13-1967 , that (I) (we) lost saw the deceased alive on 9-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Corazon Z. Vergara		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-13-67	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA		23D. ADDRESS CHURCH HOME & HOSPITAL 100 N. BROADWAY BALTIMORE MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/67		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967			
25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE			

9-13-67

Corson, E. Virginia
Corson, E. Virginia

SHAWNEE HALL & GARDEN
100 N. HARRISON
WHEELING, W. VA.

YES

Calculation of Cost

Weight - 2000

Price per pound - \$1.50

1000 POUNDS

Price

Weight

0.25

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8832

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOAN

DALE

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1967 2:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania B. COUNTY Luzerne

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Hudson

D. STREET ADDRESS (If rural, give location)

40 Center Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

5-27-1939

9. AGE (in years
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3 15

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

US 17

13. FATHER'S NAME

Elmer Talmadge. (Pa.)

14. MOTHER'S MAIDEN NAME

Stella Fearthoff (Pa.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL
SECURITY NO.

17. INFORMANT

John Talmadge 11 Tinker Rd

ADDRESS

Balto. 20, Md.

18.

E 823.41

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Earles Road - 3696 Ft. N.

of Eastern Avenue

21D TIME
OF INJURY
(APPROX.)

9/11/67

12:08 A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subj. passenger in car
ran off road and turned over.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/11/67

23A. BURIAL CREMATION,
REMOVAL

Removal &

23B. DATE

Sept 14, 67

23C. NAME of CEMETERY or CREMATORY

Maple Hill Cemetery

23D. LOCATION

(City, town, or county)

Hanover Township Pa.

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1967

24B. NAME OF REGISTRAR

Philip E. Farber

24C. FUNERAL DIRECTOR

John G. Connelly Sons

ADDRESS

Essex, Md.

11/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 8833	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 8833 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) HAROLD J. GIBSON			2. DATE AND HOUR OF DEATH SEPT. 10, 1967 12:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL			A. STATE MARYLAND B. COUNTY Baltimore		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 422 DELAWARE AVE.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/1/06	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10B. KIND OF BUSINESS OR INDUSTRY DAIRY KOONTZ		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME J. GIBSON		
14. MOTHER'S MAIDEN NAME DEC			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 191-03-7453			17. INFORMANT DENA GIBSON		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary emboli, massive			ADDRESS SAME AS ABOVE		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Ilia Thrombosis (B) DEATH (C) 3		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/31/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 45	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/30 19 67 to 9/10 19 67 , that (I) (we) last saw the deceased alive on 9/10/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles M. Harrison				23B. DATE SIGNED 9/10/67	
23C. PHYSICIAN'S NAME (Type) CHARLES M. HARRISON				23D. ADDRESS M.D. MARYLAND GENERAL HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/13/67		24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE	
24D. LOCATION BALTO.		24E. STATE MD.		24F. ADDRESS 300 More Ave. 21	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR J. J. Connelly, Inc.	

Volume 1
Page 1
The first
of the
series

22

3

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67-8834		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8834	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		FREDERICK N. (Monks)		2. DATE AND HOUR OF DEATH SEPT. 13 1967 3:55A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL CATON & WILKENS BALTO 21229 MD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-04		D. STREET ADDRESS (If rural, give location) 4406 ADELLE TERRACE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 09/07/02	9. AGE (In years lost in day) 65	10. Under 1 Tr. Months, Days, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10B. KIND OF BUSINESS OR INDUSTRY CONSOLIDATED ENG.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME FREDERICK N. Monks		14. MOTHER'S MAIDEN NAME UNKNOWN Katherine Jones	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 217-09-1034		17. INFORMANT ST AGNES ADMISSION SLIP	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Shock (Cardiogenic) Myocardial Infarction 1 Week		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Hrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPT. 9 1967 to SEPT. 13 1967, that (X) (we) last saw the deceased alive on SEPT. 13 1967 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond D. Bah		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/13/67	
23C. PHYSICIAN'S NAME (Type) RAYMOND D. BAH		23D. ADDRESS 54 Agnes Hwy			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 16, 1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR G. Truman Schwab	
25C. FUNERAL DIRECTOR G. Truman Schwab		25D. ADDRESS 3512 Frederick Ave.		Balto. Md.	

AD-2

UNITED STATES

DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

RECEIVED

APR 11 1964

U.S. DEPARTMENT OF JUSTICE

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U.S. DEPARTMENT OF JUSTICE

APR 11 1964

U.S. DEPARTMENT OF JUSTICE

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211-00-10000, ET ALAS, ADMISION 211

211

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

36-94-41 IN		H-400 67 8835		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 67 8835	
BIRTH NO.		M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)	
		Franklin JOSEPH HALL				2. DATE AND HOUR OF DEATH 12 SEPTEMBER 1967 3:26A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-11			
				D. STREET ADDRESS (If rural, give location) 515 S. EAST AVENUE - 21224			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1/25/02	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph F. Hall				14. MOTHER'S MAIDEN NAME Lillia Lewis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-07-0892		17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
18. 5-27-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) COR PULMONALE DUE TO CHRONIC OBST. PUL DISEASE DUE TO PULMONARY EMBOLI				INTERVAL BETWEEN ONSET AND DEATH 5 YRS > 20 YRS 2 WKS			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that HE (this hospital) attended the deceased from 8/17 19 67 to 9/12 19 67 , that (I) was last saw the deceased alive on 12 SEPTEMBER 19 67 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE Russell D Hicks				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12 SEPT 1967	
23C. PHYSICIAN'S NAME (Type) RUSSELL D. HICKS				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/67		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR 229-8-3-10-10		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8836</u>	
BIRTH NO. <u>67 8836</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HAROLD C. LANG SR.</u>		2. DATE AND HOUR OF DEATH <u>9-12-67</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>7-01</u> D. STREET ADDRESS (If rural, give location) <u>617 NORTH KENWOOD AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>MARRIED</u>	8. DATE OF BIRTH <u>3-25-86</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager-Max Fellstein & Son</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM J. LANG</u>		14. MOTHER'S MAIDEN NAME <u>EMMA OSMOND</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-05-6096</u>		17. INFORMANT <u>523 Yarmouth Rd. 04</u> ADDRESS <u>Harold C. Lang, Jr. son,</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarct</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u>		CAUSE OF DEATH (A) <u>Myocardial infarct</u> DUE TO (B) <u>Arteriosclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>20 yr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>9/10</u> 19 <u>67</u> to <u>9/12</u> 19 <u>67</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>9/12</u> 19 <u>67</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Thomas C. Butler</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>THOMAS C. BUTLER</u> M.D.				23D. ADDRESS <u>601 N. Broadway</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/15/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1967</u>		25B. NAME OF REGISTRAR <u>Chas. E. Feltner</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> ADDRESS <u>2601 E. Madison St.</u>	

3 days
20 yr

Myocardial infarct
Anteroinferior

11/12

07

11/10

07

11/12

601 N. Broadway

THOMAS C. BUTLER
THOMAS C. BUTLER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8837				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8837	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ANNA CONOVICH</u>				2. DATE AND HOUR OF DEATH <u>9/12/67</u> <u>6:30</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 MARYLAND General</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>2905 Mc ELDERS ST</u>			
5. SEX <u>Female</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>6/25/02</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>-</u> <u>-</u> <u>-</u> <u>-</u>		If Under 24 Hrs. Hours: Min. <u>-</u> <u>-</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Katherine Krejci</u> <u>Daughter</u>		ADDRESS <u>616 RALSON AVE</u>	
18. <u>420.1 + 260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC SCARRING</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prior MYOCARDIAL INFARCT</u>				DUE TO		<u>6 MONTHS</u>	
				DUE TO		<u>15 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus</u>						<u>10 YEARS</u>	
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>-</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>8/10/67</u> 19 <u>67</u> to <u>9/12</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/11</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <u>Charles E. Schimunek</u>						23B. DATE SIGNED <u>9/12/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>-</u>						23D. ADDRESS <u>-</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/15/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1967</u>		25B. NAME OF REGISTRAR <u>Regina E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		ADDRESS <u>-</u>	

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M-501

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8838	
BIRTH NO. 67 8838		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NORMAN E. MANN		2. DATE AND HOUR OF DEATH 3:45 9/11/67 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Carroll Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) WESTMINISTER 56-00	
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) FRIZELLEBERG, Route 7	
5. SEX WM	6. RACE MW	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-21-29	9. AGE (In years last birthday) 38	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10B. KIND OF BUSINESS OR INDUSTRY Congoleum-Mann		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Mann		14. MOTHER'S MAIDEN NAME Evelyn Bowman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-9969		17. INFORMANT Mrs. May K. Mann Westminister Rt. #7, Md	
18. 350X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO SEPTIC SHOCK		INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Decubitus ulcers, pneumonia 3 wks			
		(C) DUE TO Parkinson's disease		6 yr 9 mo 1-67	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		dehydration, stress ulcer			
19A. DATE OF OPERATION 1961		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Parkinson's disease		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/11/1967 to 9/11/1967, that (I) (we) last saw the deceased alive on 9/11/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alan F. Wolf		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/11/67	
23C. PHYSICIAN'S NAME (Type) ALAN F. WOLF		23D. ADDRESS M.D. c/o SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 13, 1967		24C. NAME OF CEMETERY or CREMATORY Evergreen Mem. Gardens	
24D. LOCATION Finksburg, Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 15 1967		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR		24H. ADDRESS			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8839		67 8839		67 8839	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Bessie C. Bain			Sept. 8, 1967 2:40p M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
91 Montebello State Hospital			Md. Ann Arundel Co		
5. SEX F			6. RACE W		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
widowed			3/10/99		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years last birthday)		
none			68		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
_____			Maryland		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Unknown			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			217-26-0374		
17. INFORMANT			ADDRESS		
Hospital Chart			_____		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
332 X I			Cerebral thrombosis, bilateral		
ANTECEDENT CAUSES			21 months		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			Cerebral Arteriosclerosis years -		
II			_____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			_____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		_____		_____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
_____		_____		_____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
_____		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		_____	
22. I certify that (I) (this hospital) attended the deceased from May 18, 1966 to Sept. 8, 1967, that (I) (we) last saw the deceased alive on Sept. 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Cesar J. Pollerano M.D.				_____	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Cesar J. Pollerano M.D.				Montebello State Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-12-1967		Moreland Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 15 1967		R. E. E. Taylor		George J. Gonce-4001 Ritchie Hwy., Baltimore	
24D. LOCATION (City, town, or county)		24E. ADDRESS		24F. ADDRESS	
Baltimore, Maryland		_____		_____	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

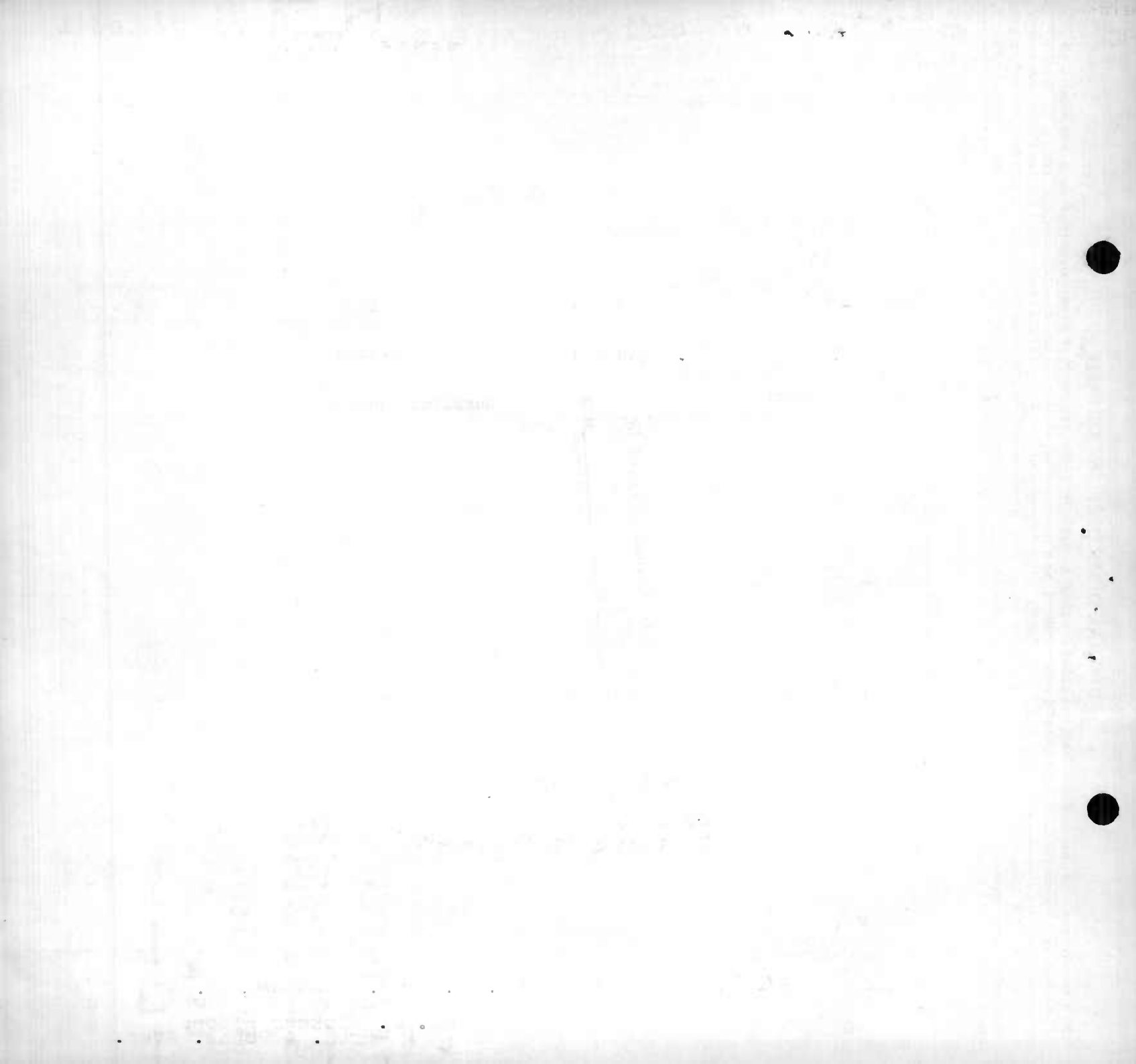
BIRTH NO. <u>67-18418 67 8840</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 8840</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby Boy Gorham</u>		2. DATE AND HOUR OF DEATH <u>9-14-67</u> <u>3:33</u> <u>A.M.</u>	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> <u>33</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>10-01</u>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>1104 EAST EAGER STREET</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>9-12-67</u>	9. AGE (in years last birthday) <u>0</u> <u>1</u> <u>6</u> <u>23</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Carl S. Ripwith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gorham</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS	
18. <u>771.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Hemorrhage</u>		CAUSE OF DEATH (A) <u>Pulmonary Hemorrhage</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3hr 33min</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory Distress</u>		(B) <u>Respiratory Distress</u> DUE TO		<u>0</u>	
(C) <u>Prematurity</u>				<u>0</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> <u>19 67</u> to <u>9-14</u> <u>19 67</u> , that (I) (we) last saw the deceased alive on <u>9-14</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B. W. Kester</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-14-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard W. Kester</u>		23D. ADDRESS <u>Box 60 Johns Hopkins Baltimore, Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>9-14-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>	
24D. LOCATION <u>BALTIMORE, MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>			
25D. ADDRESS					

22 APR 1952 JOHN HORTON BATTLES MD

No

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8841		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8841	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) JOHN KAUFMAN		
2. DATE AND HOUR OF DEATH September 9, 1967 11:00 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND 46			A. STATE Maryland B. COUNTY Baltimore		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			D. STREET ADDRESS (If rural, give location) 1803N FULTON AVENUE 15-02		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-15-84	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - RR		10B. KIND OF BUSINESS OR INDUSTRY Watchman	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME ? Kaufman			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Hospital Records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism		CAUSE OF DEATH (A) DUE TO Pulmonary Embolism (B) DUE TO Arteriosclerotic heart disease (C) Old age		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary tuberculosis (?)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3 8/29/67	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture femur, left	20A. AUTOPSY? (Yes or No) XCS	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home (1803 Fulton Avenue)			
21D. TIME OF INJURY (APPROX.) 8-23-67	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Fall at home			
22. I certify that (I) (this hospital) attended the deceased from 8/23 19 67 to 9/9 19 67 , that (I) (we) lost saw the deceased alive on 9/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Desiderio L. Hebron, Jr.			M.D.	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 9/9/67
23C. PHYSICIAN'S NAME (Type) DESIDERIO L. HEBRON, JR.			M.D.	23D. ADDRESS Lutheran Hospital of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/12/67	24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Pk. Cem.		24D. LOCATION (City, town, or county) (State) Elkridge, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Wm. J. Tickner & Sons		25C. FUNERAL DIRECTOR ADDRESS 88 North & Penna. Aves.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250		67 8842		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8842	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Emma Jackson		2. DATE AND HOUR OF DEATH Sept. 13, 1967 8 15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
5. SEX Female				6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 1-1-96		9. AGE (In years last birthday) 71	
13. FATHER'S NAME William Jackson				14. MOTHER'S MAIDEN NAME Frances Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH 4940 Eastern Avenue Baltimore, Maryland			
18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Hodgkin's Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 13 1967 to Sept. 13 1967, that (I) (we) last saw the deceased alive on Sept. 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ross T. Krueger				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 13, 1967	
23C. PHYSICIAN'S NAME (Type) Ross T. Krueger				23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/16/67		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY		24D. LOCATION (City, town, or county) (State) AIA. County Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert E. Falcione		25C. FUNERAL DIRECTOR Joseph J. Rook		25D. ADDRESS 1304 N. Central Ave	

1-1-1

Hodgkin's Disease

25 1 1952



25 1 1952

25 1 1952



25 1 1952

x

Good T. Transfer
Good T. Transfer

Good T. Transfer
Good T. Transfer

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Cecelia E. McKay (Butler)

2. DATE AND HOUR OF DEATH

9-13-67

5:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

26 South Exeter Street

21202

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

1-30-45

9. AGE (In years
lost birthday)

22

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Leroy Butler

14. MOTHER'S MAIDEN NAME

Elizabeth Russell

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCM-4940 Eastern Avenue 21224

18. 465 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cardiac Arrest

DUE TO

2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Acute Cor pulmonale

DUE TO

9 hrs

(C) pulmonary emboli, multiple 15 days

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 12 1967 to Sept 13 1967, that (I) (we) last saw the deceased alive on Sept 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. Lowmiller

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9-13-67

23C. PHYSICIAN'S
NAME (Type)

M. Lowmiller

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/16/67

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

Baltimore Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 15 1967

Kelson Funeral Home 1348 N. Calhoun st.

Kelson Funeral Home 1348 N. Calhoun st.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-346

THE CITY HEALTH



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8844</u>	
BIRTH NO. <u>67 8844</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>John Tibbs</u>		2. DATE AND HOUR OF DEATH <u>Sept. 13, 1967</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1915 McCulloh St.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1915 McCulloh St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>12/24/96</u>	9. AGE (in years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>			
16. SOCIAL SECURITY NO. <u>217-07-7675</u>		17. INFORMANT <u>Martha Tibbs 1915 McCulloh St.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>General Carcinomatosis</u>		CAUSE OF DEATH (A) DUE TO <u>Carcinoma of Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>18 months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 10 1966</u> to <u>Sept 13 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 12 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Wm. L. Berry</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9-14-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Wm. Leroy Berry</u>		23D. ADDRESS <u>1237 N. Caroline St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/18/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Natl. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Kelson Funeral Home 1348 N. Calhoun St.</u>			
25D. ADDRESS					

Handwritten text, likely a signature or name, appearing in the upper right quadrant of the page.

Handwritten text, possibly a date or a short phrase, located in the center of the page.

Handwritten text, possibly a signature or name, appearing in the lower right quadrant of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 8846					Registered No. 67 8846					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) BROWN, MACKIE					2. DATE AND HOUR OF DEATH 9/1/67 9 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 20-06					
5. SEX M 6. RACE C 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower					8. DATE OF BIRTH 3/27/1900 9. AGE (In years last birthday) 85					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER					11. BIRTHPLACE (State or foreign country) Columbus N.C.					
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					
17. INFORMANT ESSIE CANTY					ADDRESS Balto. 13 S. Hilton St.					
18. 5-78X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE RECTAL BLEEDING ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. UNDETERMINED CAUSE					INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 8/28 1967 to 9/1 1967 , that (I) (we) last saw the deceased alive on 9/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE FQW					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9/1/67		
23C. PHYSICIAN'S NAME (Type) FERNANDO QUERAL					23D. ADDRESS LUTHERAN HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 9/6/67			24C. NAME OF CEMETERY or CREMATORY Evergreen Cemetery			24D. LOCATION (City, town, or county) (State) Columbus N.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967			25B. NAME OF REGISTRAR Robert E. Stahler			25C. FUNERAL DIRECTOR Smith Funeral Home			ADDRESS White Hall, N.C.	

5/1/67

5/1/67

NO

BALTIMORE

LUTHERAN HOSPITAL

13 SOUTH ST.

87

M C

MASSIVE RECTAL BLEEDING

UNDETERMINED CAUSE

NO

5/1/67

5/1/67

8/28/67

5/1/67

POW

FERNANDO GUERIN

X

5/1/67

LUTHERAN HOSPITAL

BIRTH NO. 67 8847 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8847

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHNSON (Baby Girl) (THERESA)

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1967 1:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3224 Cherryland Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

AUG 8, 1967

9. AGE (in years
lost birthday)

1 MO

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

1 7

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

CHARLES R. JOHNSON

14. MOTHER'S MAIDEN NAME

DELORES GATTLING

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

CHARLES R. JOHNSON

ADDRESS

S/A

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial Pneumonitis (SDII)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/15/67

23C. NAME OF CEMETERY or CREMATORY

MOUNT AUBURN

23D. LOCATION

(City, town, or county)

(State)

BALTO. Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1967

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

J.L. BROWN & SON

ADDRESS

123 W. MONTGOMERY ST.

(100-2307)

MAILED FOR

RECEIVED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8848		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8848	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ELMER VAN VALKENBURGH			2. DATE AND HOUR OF DEATH 9/14/67 00.15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4801 NORWOOD ROAD.		
5. SEX M	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/27/1892	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT OFFICE MGR WHSE FLORIST		10B. KIND OF BUSINESS OR INDUSTRY NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME VAN VALKENBURGH			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 111-18-7401		17. INFORMANT ADDRESS MRS EDNA VAN VALKENBURGH SAME	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Acute anterior myocardial infarction DUE TO (B) arteriosclerotic coronary disease DUE TO (C) W.K.W.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>SEPTEMBER 11 19 67</u> to <u>SEPTEMBER 14 19 67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>SEPTEMBER 14 19 67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Enrique Cipriani			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/14/67
23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI			23D. ADDRESS THE UNION MEMORIAL HOSPITAL 33rd and CALVERT STS.		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9-16-67		24C. NAME of CEMETERY or CREMATORY Greenmount	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.			

8-28-70 10:00 AM - 10:00 PM

State of New York
County of Albany
1970

THE PEOPLE OF THE STATE OF NEW YORK

1970

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-94-72 CG		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8849	
BIRTH NO. 67 8849		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RICHARD JACKSON		2. DATE AND HOUR OF DEATH 6.30 PM 9/18/1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. DATE OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITAL 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND		A. STATE MARYLAND B. COUNTY 19-02			
6. RACE MAKE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH JAN 10, 1906	
9. AGE (In years, lost birthday) 61		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10. B. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) Cooksville, Md		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME GEORGE JACKSON		14. MOTHER'S MAIDEN NAME SARAH DORSEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224, MD.	
18. 331X4012.3		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO CEREBRAL VAS. ACCIDENT			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Chronic osteomyelitis			
		(C) Tuberculosis			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/21/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Removal plate from (R) humerus		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 1, 1967 to September 8, 1967, that (I) (yes) last saw the deceased alive on September 1, 1967 and that in (my) (yes) opinion death occurred on the date and hour and from the causes stated above. (I) (yes) (did) (did not) view the body after death.					
23A. SIGNATURE CH. G. ECONOMIDES				23B. DATE SIGNED 9/18/1967	
23C. PHYSICIAN'S NAME (Type) DR. CHRISTOS ECONOMIDES CH. G. ECONOMIDES		23D. ADDRESS BALTIMORE 21224, MARYLAND BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/67		24C. NAME OF CEMETERY OR CREMATORY JAUSA CEMETERY	
24D. LOCATION (City, town, or county) (State) Cooksville, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave	

2nd Floor
(1st Floor)

1st Floor
(2nd Floor)

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0/0/0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 8850		67 8850	
BIRTH NO.		67 8850		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Guy Leon Ridout		2. DATE AND HOUR OF DEATH Sept 8, 1967 6:45 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		16-06	
FULL NAME OF HOSPITAL OR INSTITUTION 00 3008 Arunah Ave		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 3008 Arunah Ave	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 11, 1903	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10B. KIND OF BUSINESS OR INDUSTRY J.W. Trusth		11. BIRTHPLACE (State or foreign country) Mt. Gilboa, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME George Ridout		14. MOTHER'S MAIDEN NAME Bessie Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-1782		17. INFORMANT Mrs. Evelyn B. Ridout 3008 Arunah Ave	
18. 433.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Anticoagulant therapy causing vascular disease & fatal pulmonary embolism		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 14 May 1965 to 8 Sept 1967, that (I) (we) last saw the deceased alive on 10 July 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.R. Davidson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11 Sept 67	
23C. PHYSICIAN'S NAME (Type) Charles R. Davidson		23D. ADDRESS 2034 W. North Ave - Balto, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/67		24C. NAME of CEMETERY or CREMATORY Family Lot	
24D. LOCATION Churchton, Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 15 1967		24F. NAME OF REGISTRAR Robert E. Davidson	
24G. FUNERAL DIRECTOR Herbert E. Nutter		24H. ADDRESS 3035 W. North Ave		24I. DATE 9/12/67	

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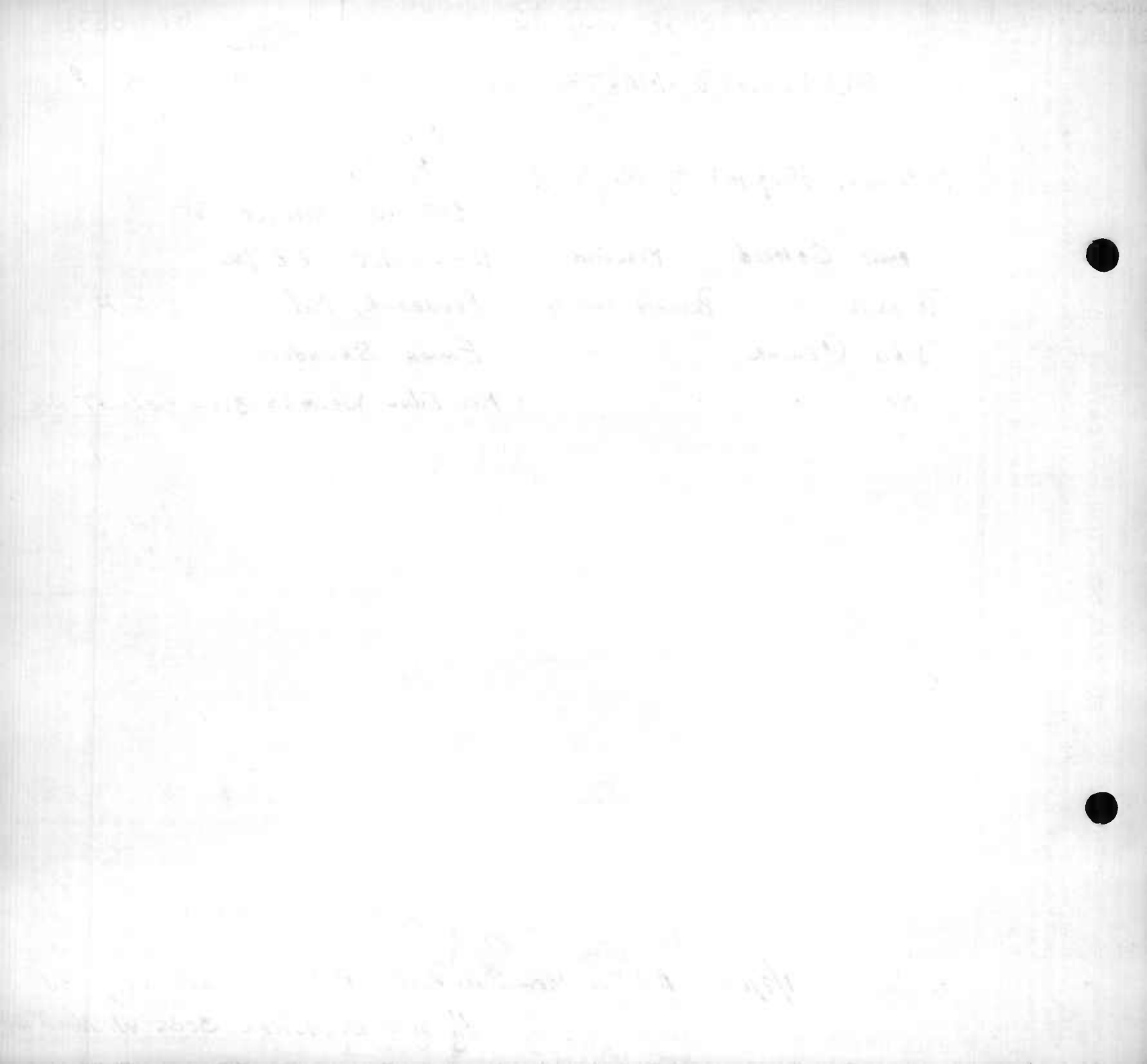
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FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 8851		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8851	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AQUILLARD MARTHA K		2. DATE AND HOUR OF DEATH 9-6-67 8 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-04			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 810 N. Monroe St.			
5. SEX FEMALE	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-2-1900	9. AGE (In years last birthday) 66 Yrs	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY		11. BIRTHPLACE (State or foreign country) FREDERICK, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John CEASAR		14. MOTHER'S MAIDEN NAME EMMA SAUNDERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. EDNA WELDON ADDRESS 3103 BELMONT AVE	
18. 444X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute Pulmonary Oedema DUE TO (B) Hypertension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days few years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-5-67 19 to 9-6-67 19 67, that (I) (we) last saw the deceased alive on 9-6-67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-6-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI		23D. ADDRESS Lutheran Hospital of Maryland 730 Ashburton St Baltimore MD. 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/9/67		24C. NAME of CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) ARBUTUS BALTO Co., MD		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Herbert E. Nutter	
25C. FUNERAL DIRECTOR HERBERT E. NUTTER		ADDRESS 3035 W. North Ave			



4-1600
9-10-67
Dr Palmisano
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67 8852		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8852	
M.E. CASE NO.			2		
1. NAME OF DECEASED (Type or Print) NELLIE J. HARE			2. DATE AND HOUR OF DEATH 9-10-67 10:35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION Memorial Hosp.			A. STATE md. B. COUNTY 27-03		
5. SEX F			6. RACE N		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow			8. DATE OF BIRTH 3-17-89		
9. AGE (In years last birthday) 78			10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Mgr.			11. BIRTHPLACE (State or foreign country) md.		
10B. KIND OF BUSINESS OR INDUSTRY Severn Apt.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles J. HARE			14. MOTHER'S MAIDEN NAME MARY BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO. 215-07-3277		
17. INFORMANT MRS. HENERITA CROLL (Friend)			ADDRESS SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Attack (Thrombosis)			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.			20. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
19A. DATE OF OPERATION 9-9-67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 9-9-67 to 9-10-67, that (I) (we) lost saw the deceased alive on 9-10-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			23A. SIGNATURE Frank Palmisano M.D.		
23B. DATE SIGNED 9-10-67			23C. PHYSICIAN'S NAME (Type) DR FRANK PALMISONIA		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9/14/67		
24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem			24D. LOCATION Baltimore Co. Md		
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967			25B. NAME OF REGISTRAR Herbert E. Muttler		
25C. FUNERAL DIRECTOR			ADDRESS 3035 W NORTH AVE		

Handwritten notes on the right margin, including "C. 200" and "C. 200" repeated.

10-10-07 10:32 A

10-10-07 10:32 A

Union Memorial #205

3336 IVY AVE.

F N Widow

3-17-88 JR

Charles (husband)

Wife

UNKNOWN

MARK (husband)
Wife (husband)
Charles (husband)

2-2-88

Charles (husband)
(husband)
3-17-88
Charles (husband)
Wife (husband)
Charles (husband)

2-2-88

Charles (husband)
Wife (husband)
Charles (husband)
Wife (husband)
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Charles (husband)
Wife (husband)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 8853	
BIRTH NO. 67 8853							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Alice Cosby				2. DATE AND HOUR OF DEATH September 7, 1967		9:05 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital Inc. 1514 Division Street Baltimore, Maryland 21217				A. STATE Maryland			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1117 North Monroe			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED (specify)		8. DATE OF BIRTH 2/18/83	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Florida, (East Palatka)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown (Ashley Norris)				14. MOTHER'S MAIDEN NAME Unknown (Nancy Babe :-)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nettie Cosby (sis-in-law)		ADDRESS #1 Lincoln Ave.	
18. 445X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO Conjestic Heart Failure		1 week	
				(B) DUE TO HASHD Myocardial damage		years	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from September 6, 19 67 to September 7, 19 67 , that (H) (we) last saw the deceased alive on September 7, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Elijah Saunders</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/7/67	
23C. PHYSICIAN'S NAME (Type) Elijah Saunders				23D. ADDRESS 3414 Duvall Ave. Balto., Md. 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/67		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR <i>Herbert E. Nutter</i>		25C. FUNERAL DIRECTOR ADDRESS 3035 W. North Ave			

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G. 650

67 8854

BALTIMORE CITY HEALTH DEPARTMENT

67 8854

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEE GREEN

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1967 8:14 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43/99 South Baltimore General (DPA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1600 N. Rosedale Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov 26, 1934

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Md Drydock Co

11. BIRTHPLACE (State or foreign country)

Jackson, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Thomas Green

14. MOTHER'S MAIDEN NAME

Minnie Goods

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

237-52-6259

17. INFORMANT

Mrs. Bernice Green 1600 Rosedale St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebrocranial injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) ship in drydock21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Maryland Drydock, Fairfield

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9-8-67 6:45 A.

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE
AT WORK ☐21F. HOW DID INJURY OCCUR?
Fell from ladder
while climbing from ballast tank

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/13/67

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

Arbutus

(City, town, or county)

Balto Co.

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Herbert E. Nutter

ADDRESS

3035 W. North Ave

WILLIAM L. POLING

WILLIAM L. POLING

WILLIAM L. POLING

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8855		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8855	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MINNIE NOBBS GRAHAM		2. DATE AND HOUR OF DEATH 9-14-67 18:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND - BALTIMORE CO. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) TOWSON 04 53-00 D. STREET ADDRESS (If rural, give location) 509 EAST JOPPA ROAD			
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 01-05-73	9. AGE (In years last birthday) 94	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (NOT KNOWN)		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME FRANK D. NOBBS		14. MOTHER'S MAIDEN NAME ADA ROBINSON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 168-03-2157		17. INFORMANT HOSPITAL ADMISSION HISTORY			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.01		CAUSE OF DEATH (A) Bronchopneumonia (B) ASH D (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 10 19 67 to SEPTEMBER 14 19 67 , that (I) (we) lost saw the deceased alive on SEPTEMBER 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce E. Cathey		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 9-14-67		
23C. PHYSICIAN'S NAME (Type) BRUCE E. CATHEY		23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE Sept. 14, 1967	24C. NAME of CEMETERY or CREMATORY GREENMOUNT Crematory		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Wm. Cook-Brooks	
				ADDRESS 1050 York Rd. Towson, Md.	

MINUTE BOOKS GRAHAM 8-20 P 11-17

MARYLAND - BALTIMORE CO.

TOWSON PD

UNION MEMORIAL HOSPITAL 207 EAST 109th ROAD

01-02-13 PD

PENNSYLVANIA U.S.

(not known)

ADA ROBINSON

FRANK D. MORRIS

18-03-2127 HOSPITAL ADMISSION HISTORY

No

YES

SEPTEMBER 11 03 SEPTEMBER 10 03 SEPTEMBER 11 03

X 4-4-03

UNION MEMORIAL HOSPITAL

BRUCE E. CATHEY
BRUCE E. CATHEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8856	
BIRTH NO. 67 8856		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) BERTHA MAY TRACEY		9-10-67 2:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP.		A. STATE md. B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.	
		D. STREET ADDRESS (If rural, give location) 2923 CRESMONT AVE.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow	8. DATE OF BIRTH 7-17-90
		9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) BALTO. md.
13. FATHER'S NAME GEORGE AUTS		14. MOTHER'S MAIDEN NAME ANNIE E. CRAIG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. ?	17. INFORMANT ADDRESS (daughter) MRS. BETTY L. SHERMAN (same)
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ASEVD & thrombotic occlusion of coronary artery		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Manual J. J. J.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-9-1967 to 9-10-1967 , that (I) (we) last saw the deceased alive on 9-10-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Frank S. Palmisano		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 9-10-67
23C. PHYSICIAN'S NAME (Type) FRANK S. PALMISANO, JR.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/13/67	24C. NAME of CEMETERY or CREMATORY Lorraine Park Cem.	24D. LOCATION (City, town, or county) (State) Balto. Co., Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.

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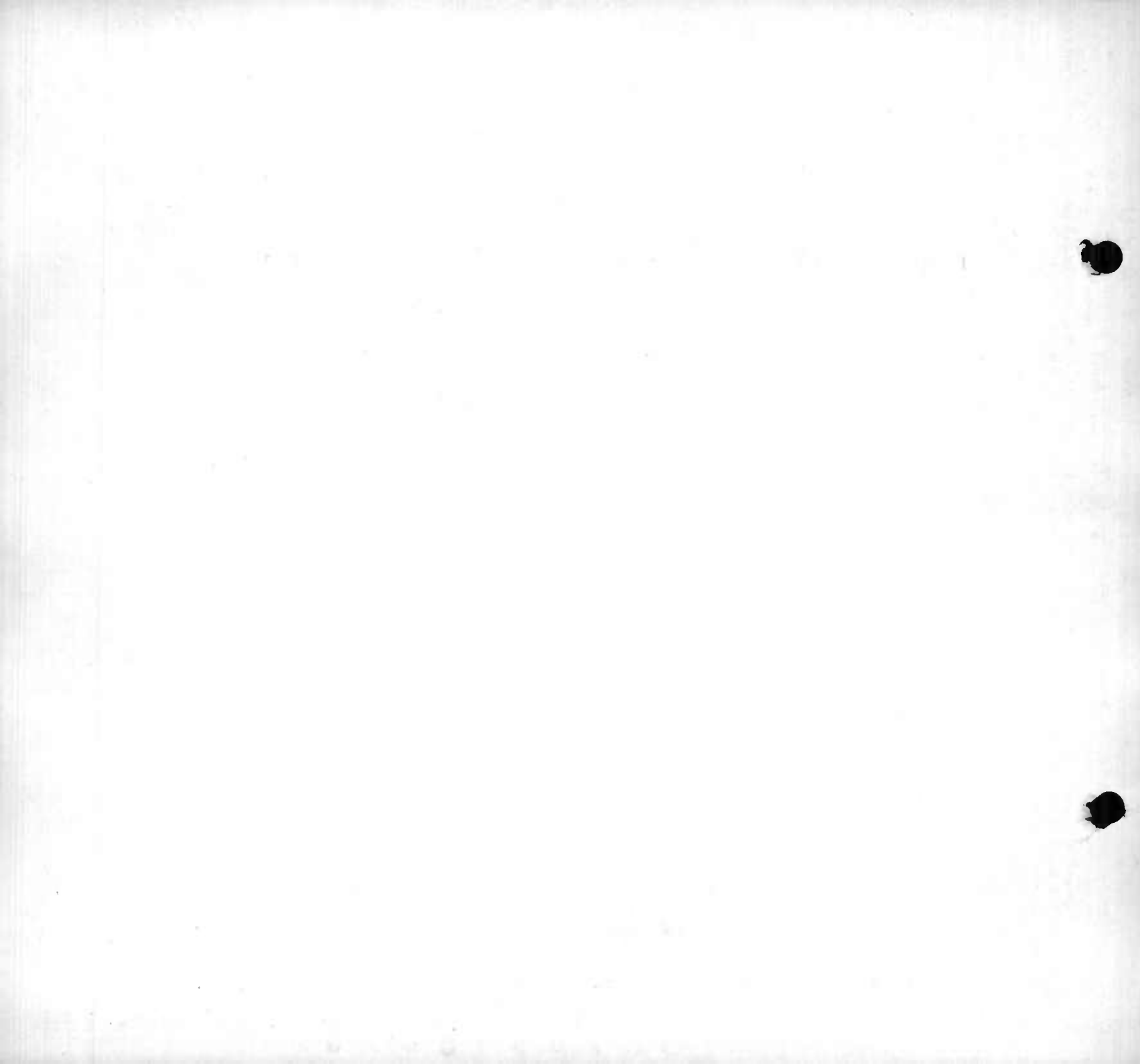
BIRTH NO.		67 8857		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 8857	
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) HARRY LEE TAYLOR					2. DATE AND HOUR PRONOUNCED DEAD September 11, 1967 1:45 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore Hospital (DOA)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE North Carolina B. COUNTY Burlington C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burlington D. STREET ADDRESS (If rural, give location) 207 James Street				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 14, 1911	9. AGE (in years last birthday) 56	11. BIRTHPLACE (State or foreign country) Burlington, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor-trailer driver					10B. KIND OF BUSINESS OR INDUSTRY Trucking Ind.				
13. FATHER'S NAME ?					14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 225-10-1164		17. INFORMANT Richard Thompson F. H. Burlington, N.C.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ? II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ?					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 2/22/67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ?		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 9/12/67			
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9/14/67		23C. NAME of CEMETERY or CREMATORY Alamance Cemetery		23D. LOCATION (City, town, or county) (State) Alamance Co., N.C.			
24A. DATE REC'D BY HEALTH DEPT. SEP 15 1967			24B. NAME OF REGISTRAR Robert E. Farley, M.D.			24C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St Paul St.			

WALLACE PROJECT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-230 BIRTH NO.		67 8858		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8858	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JAMES V. VOIGHT				9-9-67 3:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital				A. STATE MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21223 19-03			
D. STREET ADDRESS (If rural, give location) 211 S. Gilmore Street							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED		8. DATE OF BIRTH 5-13-05	9. AGE (In years lost birthday) 62	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME BENJAMIN F. Voight				14. MOTHER'S MAIDEN NAME Emily Dixon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Pts. Chart		ADDRESS	
18. 002.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Active pulmonary tuberculosis with massive hemorrhage (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-8-67 to 9-9-67, that (I) (we) lost saw the deceased alive on 9-9-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]						23B. DATE SIGNED 9-9-67	
23C. PHYSICIAN'S NAME (Type) CESAR BRAVO M.D.				23D. ADDRESS Bon Secours Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9/15/67		24C. NAME OF CEMETERY or CREMATORY Green Mount		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md. 21202			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> BIRTH NO. W-262 67 8859 BALTIMORE CITY HEALTH DEPARTMENT </div>		CERTIFICATE OF DEATH		Registered No. 67 8859	
1. NAME OF DECEASED (Type or Print) Katherine Wicherski			2. DATE AND HOUR OF DEATH 9/14/67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="text-align: center;"> CERTIFICATE AMENDED 10-17-67 </div>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Mass. B. COUNTY New Bedford		
5. SEX Female			6. RACE White		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH May 25, 1887		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Poland		
10B. KIND OF BUSINESS OR INDUSTRY Own Home			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Paleszka			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. Shick Funeral Home New Bedford, Mass		
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteroselectic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH many years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis			DUE TO senility		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-18-1965 to 9-14-1967 , that (I) (was) last saw the deceased alive on 8-2-1967 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) (view) view the body after death.					
23A. SIGNATURE Max R. English				23B. DATE SIGNED 9-14-67	
23C. PHYSICIAN'S NAME (Type) Max R. English M.D.				23D. ADDRESS 5713 Belair Rd Baltimore Md 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/67		24C. NAME of CEMETERY or CREMATORY Pine Grove	
24D. LOCATION New Bedford, Mass		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md. 21202			

Marriage Record from New Bedford, Mass.
for Adolf Wicherski and Catherine Paleszka
dated August 27, 1907 - Bride age 20 yrs.
10-17-67 M.H.

1		M-240 67 8860 BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 67-15877		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 67 8860	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
CHARLES WILLIAM MC GILL		September 8, 1967 9:40 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 1715 St. Paul Street		A. STATE Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-05	
		D. STREET ADDRESS (If rural, give location) 1715 St. Paul Street - 3rd Floor	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single-Infant	8. DATE OF BIRTH 8-15-67
9. AGE (In years last birthday) 3 weeks		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Wm. Seigmyer		14. MOTHER'S MAIDEN NAME Edna Morris Magill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Edna Morris Magill		ADDRESS 1715 St. Paul St.	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) Interstitial pneumonitis (SDII) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 8, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9/11/67	
23C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore City, Md.	
24A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		24B. NAME OF REGISTRAR Robert E. Taylor	
24C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St.	

QUALITY POINT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8861	
BIRTH NO. 67 8861		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>John Dochter MAN</i>		2. DATE AND HOUR OF DEATH <i>9/14/67 1220 P M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY of MARLAND HOSPITAL</i>		A. STATE <i>Balt. MARYLAND</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 26-08</i>			
		D. STREET ADDRESS (If rural, give location) <i>3728 Hugh Street G-08-H</i>			
5. SEX <i>MALE</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>12/10/99</i>	9. AGE (In years lost birthday) <i>67</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>City Work</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Louis</i>		14. MOTHER'S MAIDEN NAME <i>Martina</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>720-69-3880</i>		17. INFORMANT ADDRESS <i>MRS GUNTHER & Patients Wife</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>023X I</i>		CAUSE OF DEATH <i>301 Eastern Ave</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 MINUTES</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>MYOCARDIAL INFARCTION</i>		<i>10 MINUTES</i>	
		(B) DUE TO <i>MYOCARDIAL ISCHEMIA</i>		<i>2 DAYS</i>	
		(C) DUE TO <i>LUETIC AORTITIS</i>		<i>?</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>CEREBROVASCULAR DISEASE -</i>			
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 9</i> 19 <i>67</i> to <i>Sept 14</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Sept 14</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stephen Hameroff</i>				23B. DATE SIGNED <i>9/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>STEPHEN HAMEROFF</i>				23D. ADDRESS <i>University Hospital Balt MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/17/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Oak Lawn Cem.</i>	
24D. LOCATION <i>Balts. Md</i>		24E. CITY, town, or county		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Joseph M. Zimmmer</i>	
25D. ADDRESS <i>263 S. Conkey</i>					

17th Nov 1914

18th Nov 1914

19th Nov 1914

20th Nov 1914

21st Nov 1914

22nd Nov 1914

23rd Nov 1914

24th Nov 1914

25th Nov 1914

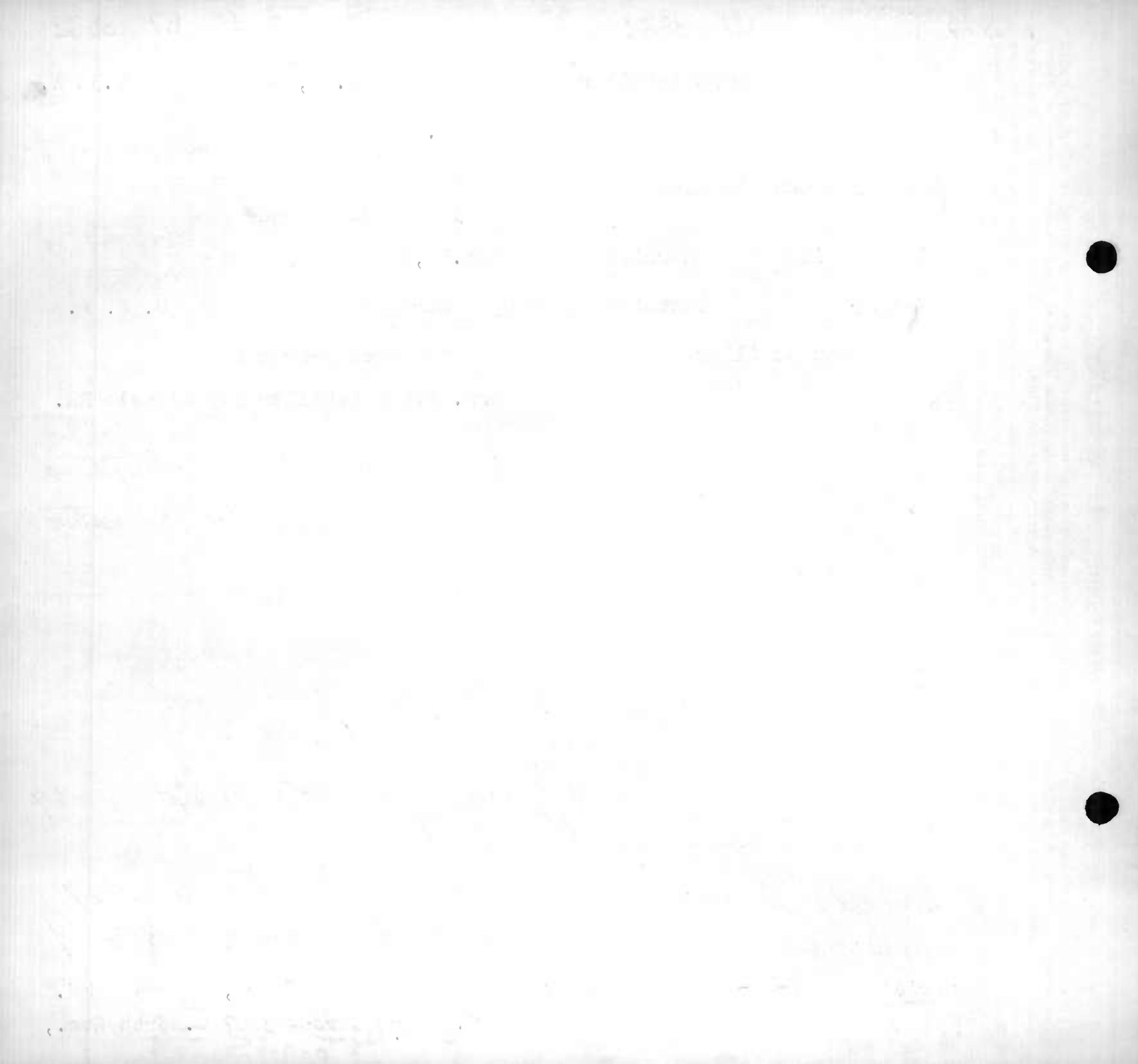
26th Nov 1914

27th Nov 1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

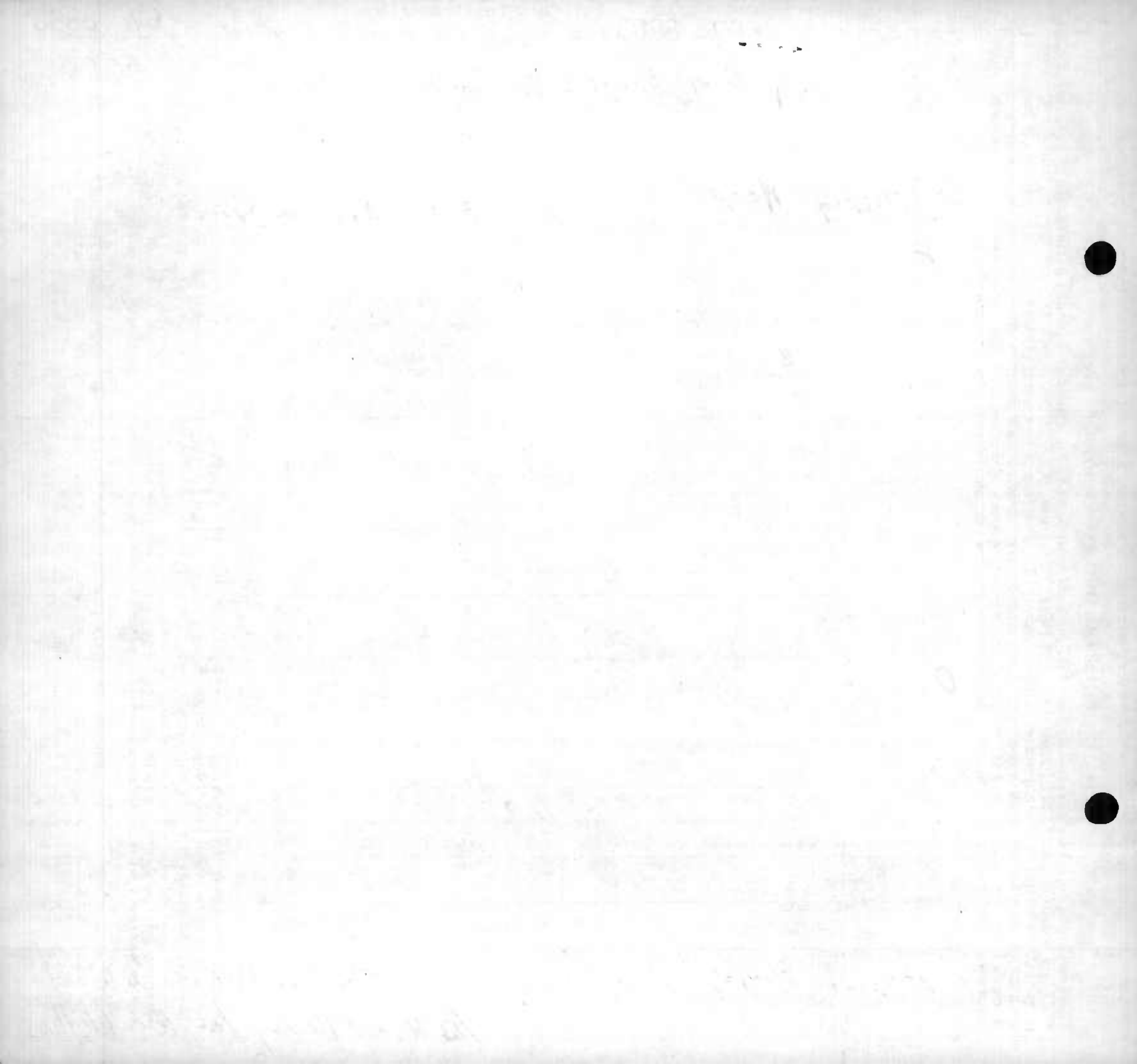
BIRTH NO. 67 8862				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8862	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Lorenz Schiller		Sept. 14, 1967 9.30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 60 309 Edsdale Road				A. STATE Md.			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 309 Edsdale Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 12, 1883	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Clothing Industry		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lorenz Schiller				14. MOTHER'S MAIDEN NAME Margaret Wehrwein			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Elvira Schiller 309 Edsdale Rd.			
18. 43311 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Acute Cardiac Failure & arrhythmia</i> DUE TO (B) <i>Arteriosclerotic Myocardial Degeneration</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to 14 Sept 1967, that (I) (we) last saw the deceased alive on 14 Sept 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>William J. Bryson</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 15 Sept 67			
23C. PHYSICIAN'S NAME (Type) William J. BRYSON				23D. ADDRESS M.D. 4605 Edmondson Ave Balto 29.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-18-1967		24C. NAME of CEMETERY or CREMATORY Western		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1967		25B. NAME OF REGISTRAR G. Howard Strong		25C. FUNERAL DIRECTOR ADDRESS 3207 W. North Ave.,			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
BIRTH NO. 67-18151 57. 8863					CERTIFICATE OF DEATH					Registered No. 67 8863														
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Braatz Dina Dorene</i>										2. DATE AND HOUR OF DEATH <i>9/12/67</i> <i>3:15 P</i> M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hosp</i>					(If not in hospital or institution, give street address or location)					A. STATE <i>md</i> B. COUNTY <i>Balto</i>														
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Linthicum</i>										D. STREET ADDRESS (If rural, give location) <i>3139 Myerson Circle</i>														
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i>		8. DATE OF BIRTH <i>9/12/67</i>		9. AGE (In years last birthday) <i>0</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>					12. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
13. FATHER'S NAME <i>James Braatz</i>										14. MOTHER'S MAIDEN NAME <i>Geraldine Waldecker</i>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>					16. SOCIAL SECURITY NO. <i>—</i>					17. INFORMANT <i>James Braatz</i>					ADDRESS									
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>sub dural tap</i>										CAUSE OF DEATH (A) DUE TO <i>Prolapsed Umbilical cord</i>					INTERVAL BETWEEN ONSET AND DEATH <i>45 min appr.</i>									
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) DUE TO <i>Breech Presentation</i>														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Rt Pneumothorax + Cervical Emphysema</i>										20A. AUTOPSY? (Yes or No) <i>NO</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
19A. DATE OF OPERATION <i>Thoracentesis</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Rt Pneumothorax</i>					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <i>9/12/67</i> 19 to <i>9/12/67</i> 19, that (I) (we) last saw the deceased alive on <i>9/12/67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																								
23A. SIGNATURE <i>Chester C Collins M.D.</i>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>9/12/67</i>									
23C. PHYSICIAN'S NAME (Type) <i>Chester C Collins</i>										23D. ADDRESS <i>M.D. Mercy Hosp.</i>														
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>9/14/67</i>					24C. NAME OF CEMETERY or CREMATORY <i>Holy Rosary Cn.</i>					24D. LOCATION (City, town, or county) (State) <i>1300 Germantown Rd Balto Md</i>									
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 18 1967</i>					25B. NAME OF REGISTRAR <i>R. E. Taylor</i>					25C. FUNERAL DIRECTOR <i>Thomas J. Kenny</i>					ADDRESS <i>1600 Hollins</i>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Austin P. Funk		2. DATE AND HOUR OF DEATH 9/14/67 5:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Eastpoint 53-00 D. STREET ADDRESS (If rural, give location) 7707 Braddock Avenue 21224	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-21-1914
9. AGE (In years last birthday) 53		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance-Man		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernon C. Funk		14. MOTHER'S MAIDEN NAME Annie M. Parks.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-1024	
17. INFORMANT Records: BCH-4940 Eastern Avenue		ADDRESS 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5-27-21 Liver Failure Bleeding Obstructive lung disease Pulmonary Embolism		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/2 1967 to 9/14 1967 , that (I) (we) last saw the deceased alive on 9/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Benjamin D. Richman		23B. DATE SIGNED 9/14/1967	
23C. PHYSICIAN'S NAME (Type) Benjamin D. Richman		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-67	
24C. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		24D. LOCATION (City, town, or county) (State) Belair, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Charles L. Zeiler		6224 Eastern Ave. Balto., 21224, Md.	

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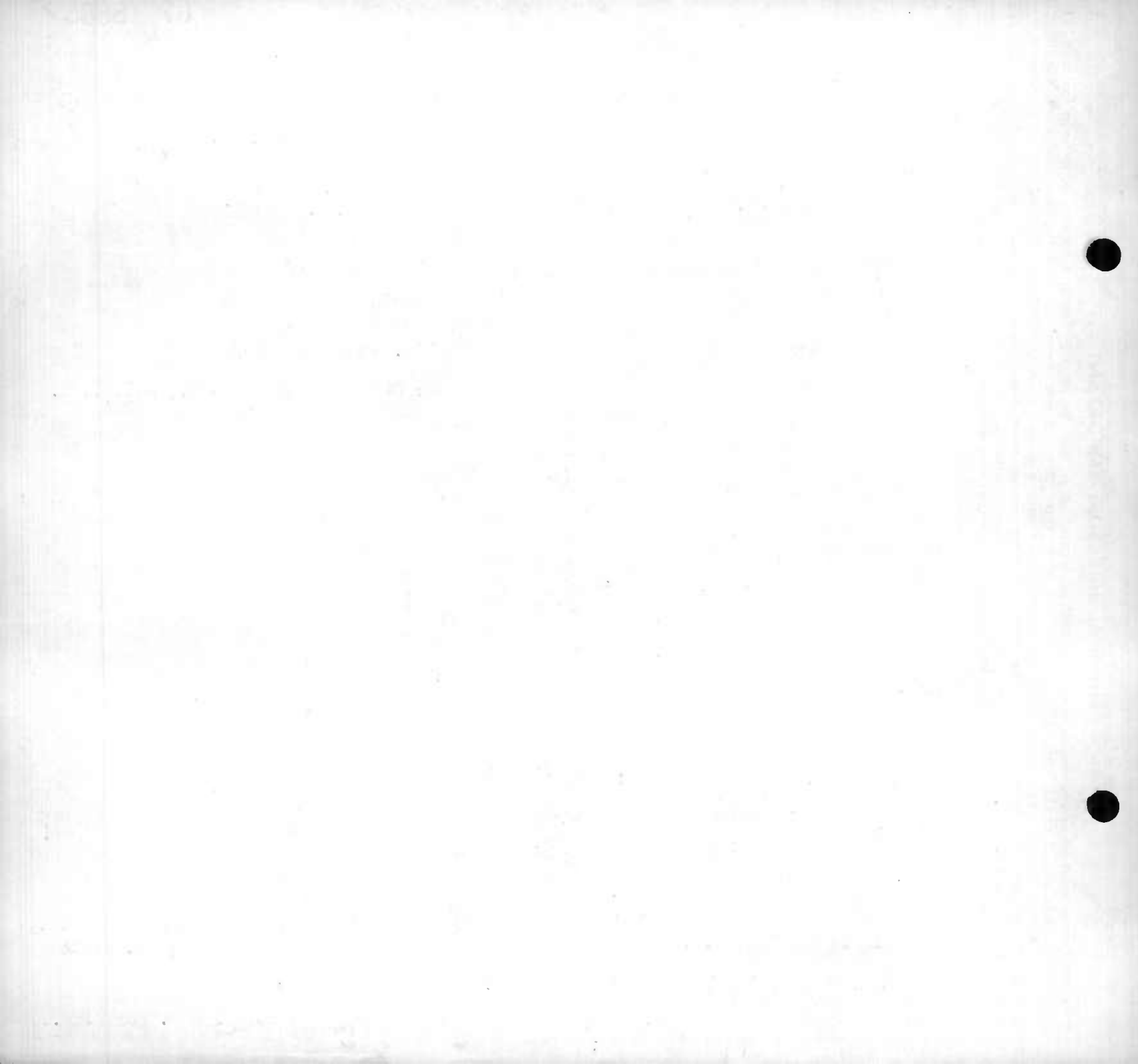
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department					
7-460 BIRTH NO.		67 8865 CERTIFICATE OF DEATH		Registered No. 67 8865	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) TAYLOR, OPAL OPAL TAYLOR				2. DATE AND HOUR OF DEATH 13 Sept. 1967 2 ⁰⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland #21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 2200 PARK AVE. #21217	
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 6-3-14	
13. FATHER'S NAME Sam Taylor		14. MOTHER'S MAIDEN NAME Eliz. Chambers Jacobs		9. AGE (In years last birthday) 53	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) West Virginia	
				12. CITIZEN OF WHAT COUNTRY? USA	
				ADDRESS RECORDS: BCH 4940 EASTERN AVE., BALTO., MD. 21224	
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Pulmonary Embolus DUE TO (B) Prolonged peripheral stasis DUE TO (C) Massive obesity	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 30 mins 15 years 15 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work [] Not While At Work []		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12 Sept. 1967 to 13 Sept. 1967 that (I) (we) last saw the deceased alive on 13 Sept. 1967 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Lechner, M.D.				23B. DATE SIGNED 13 Sept 67	
23C. PHYSICIAN'S NAME (Type) BENJAMIN LECHNER, M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTIMORE, MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/67		24C. NAME OF CEMETERY OR CREMATORY Hatfield Cemetery	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR P.O. & E. Fr. Deane		25C. FUNERAL DIRECTOR McCall's Funeral Home	
				ADDRESS 130 E. Fort Ave. 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8866		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8866	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CARRIGAN (CARRIGAN) EDWARD		2. DATE AND HOUR OF DEATH SEPT. 14 1967 3:00A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CATON & WILKENS AVE BALTO MD. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1200 VALLEY RD. ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED NEVER MARRIED	8. DATE OF BIRTH 04/17/87	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MICHAEL		14. MOTHER'S MAIDEN NAME DOLAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-0162A		17. INFORMANT ADDRESS ST AGNES ADM. SLIP CATON & WILKENS	
18. 199-2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma toxis		(A) DUE TO		(B) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from SEPT 9 19 67 to SEPT 14 19 67 , that X (we) last saw the deceased alive on SEPT 14 19 67 and that in XX (our) opinion death occurred on the date XX and hour and from the causes stated above XX (We) (did) XXX view the body after death.					
23A. SIGNATURE Pablo G. Dibos		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 09/14/67	
23C. PHYSICIAN'S NAME PABLO DIBOS, M.D.		23D. ADDRESS M.D. ST. AGNES HOSPITAL-CATON AND WILKENS AVE., BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/67		24C. NAME OF CEMETERY or CREMATORY Cathedral	
24D. LOCATION Baltimore		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Philip Herwig Sons Orleans St	
25D. ADDRESS 2024					

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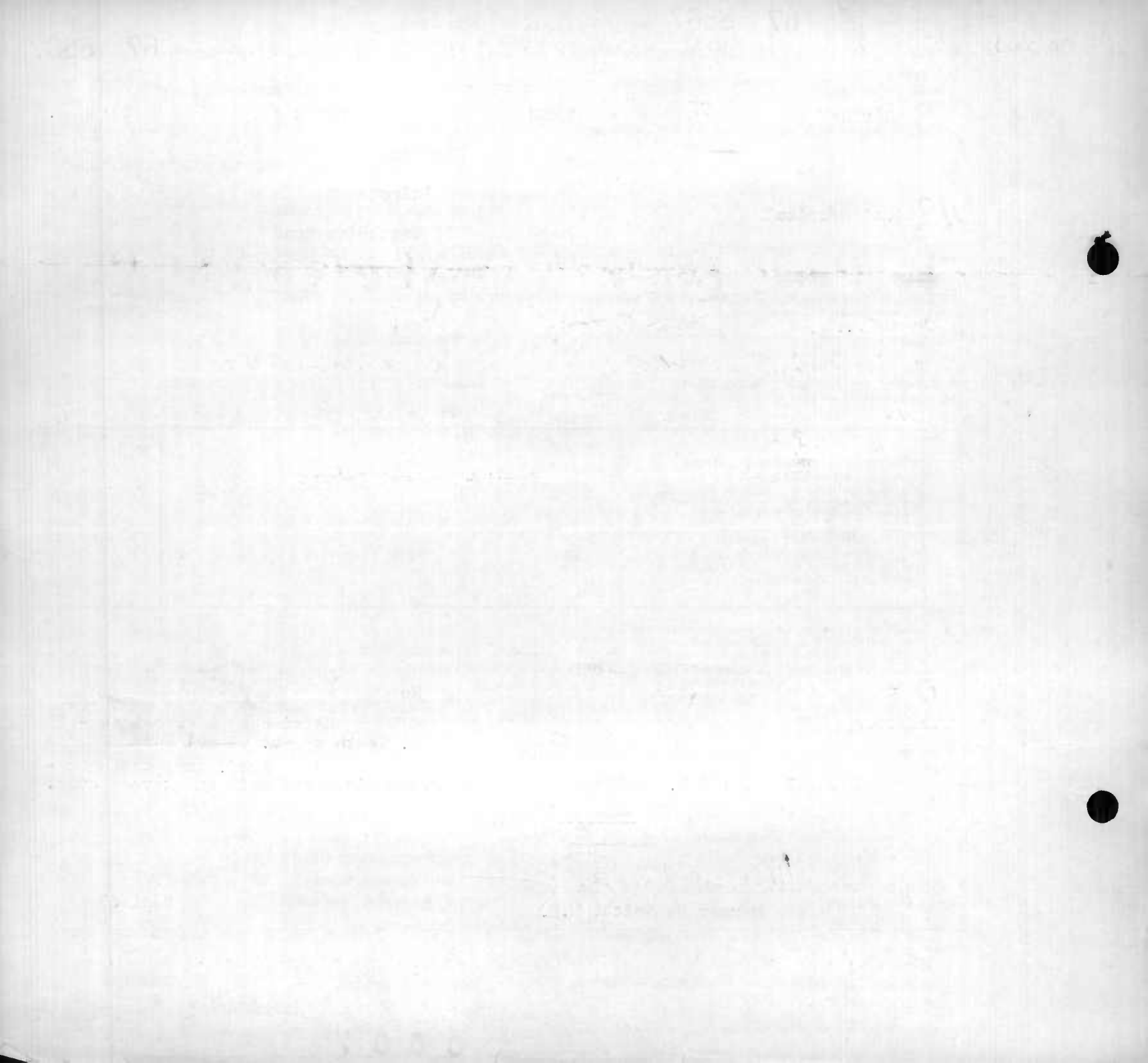
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BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67-8867

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ZACHARY T. GREEN		2. DATE AND HOUR PRONOUNCED DEAD August 31, 1967 12:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 315 Westshire Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH DEC. 23, 1904
9. AGE (In years last birthday) 62		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Floor Covering	
11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William D. GREEN		14. MOTHER'S MAIDEN NAME ROSA HILLIGIST	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth Green - 315 Westshire Rd.		ADDRESS	
18. CAUSE OF DEATH E819.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craneo-Cerebral Injury ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 0		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Harrisburg E xpressway - 1500 ft. South of Mt. Carmel Road		21D. TIME OF INJURY (APPROX.) 8/30/67 10:15 P.m.	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subj. was passenger - Truck hit guard rail and turned over.	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		DATE SIGNED 8/31/67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9-5-67	
23C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.		23D. LOCATION (City, town, or county) (State) Woodlawn Ind.	
24A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	
24C. FUNERAL DIRECTOR Goldy Corman & Son, Inc.		24D. ADDRESS 1000 E. Pratt St., Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-256		67 8868		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8868	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) TESSMER, DOROTHY SCHOESSL			
2. DATE AND HOUR OF DEATH SEPTEMBER 14, 1967 9:40 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Howard Co			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) XXXXXX ELLICOTT CITY 63-00		D. STREET ADDRESS (If rural, give location) 5 DIAMONDBACK DRIVE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 9/13/18	9. AGE (In years lost birth day) 48	10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10B. KIND OF BUSINESS OR INDUSTRY ANNE ARUNDEL CO.		11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALDO Schoessler				14. MOTHER'S MAIDEN NAME GLADYS LUNDEEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. 263-249417		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 170X I		CAUSE OF DEATH (A) Carcinoma of the Breast DUE TO (B) multiple metastasis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 16 y			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from SEPTEMBER 7 19 67 to SEPTEMBER 14 19 67, that (1) (we) last saw the deceased alive on SEPTEMBER 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Paulino Vasallo				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-14-67	
23C. PHYSICIAN'S NAME (Type) Paulino Vasallo				23D. ADDRESS M.D. St. Agnes Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/16/67		24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE		24D. LOCATION (City, town, or county) (State) ELK RIDGE, MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Paul E. Taylor		25C. FUNERAL DIRECTOR ADDRESS John H. Shook 1431 N. BOWEN - SLACK FUNERAL HOME			

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NEW YORK CITY

FUNERAL DIRECTOR: IMPORTANT

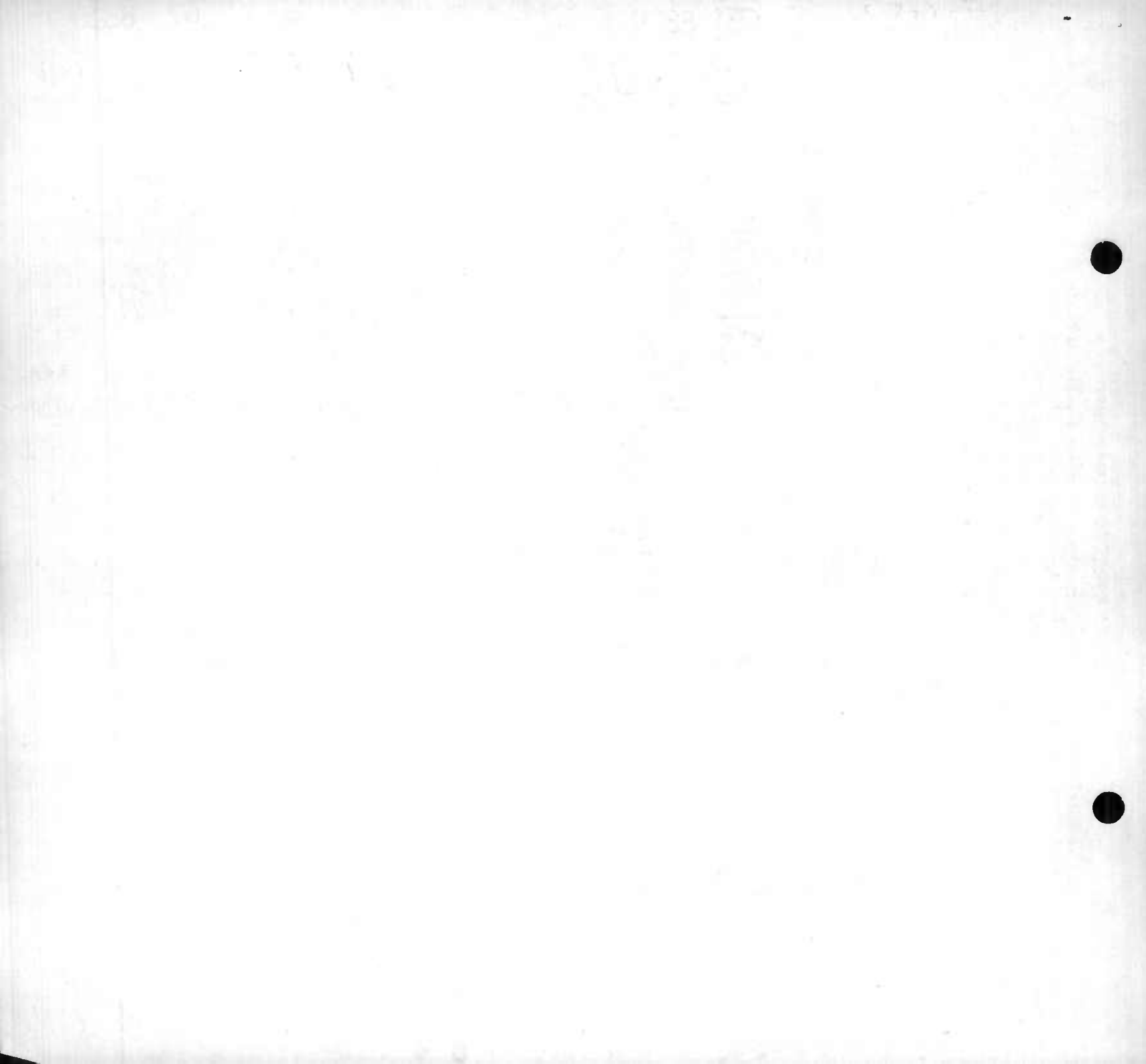
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-152 67 8869 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		Registered No. 67 8869	
BIRTH NO. 152 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MEYER CHAPNICK		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> SEPTEMBER 13, 1967 4:12 P.M. </div>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL </div> <div> (If not in hospital or institution, give street address or location) </div> </div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE MARYLAND </div> <div> B. COUNTY BALTIMORE </div> </div>	
5. SEX MALE		6. RACE WHITE	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 4-20-8914	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE MANAGER		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME WOLF CHAPNICK		14. MOTHER'S MAIDEN NAME ROSE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-16-6721	
17. INFORMANT MRS. HARRIETT CHAPNICK		ADDRESS 6316 GREENSPRING AVE.	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ventricular Fibrillation		INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction		(B) DUE TO minutes	
(C) Arteriosclerosis		unbroken	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 65 to Sept 13 19 67 , that (I) (we) last saw the deceased alive on August 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David J. Miller		23B. DATE SIGNED Sept 14, 1967	
23C. PHYSICIAN'S NAME (Type) David J. Miller		23D. ADDRESS Lusson Rd. Owings Mills Md	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-15-67	
24C. NAME OF CEMETERY or CREMATORY OHEL YAKOV CEMETERY		24D. LOCATION (City, town, or county) (State) HERRING RUN, BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Sol Levinson & Son	
25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & SON, 6010 REISTERSTOWN ROAD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

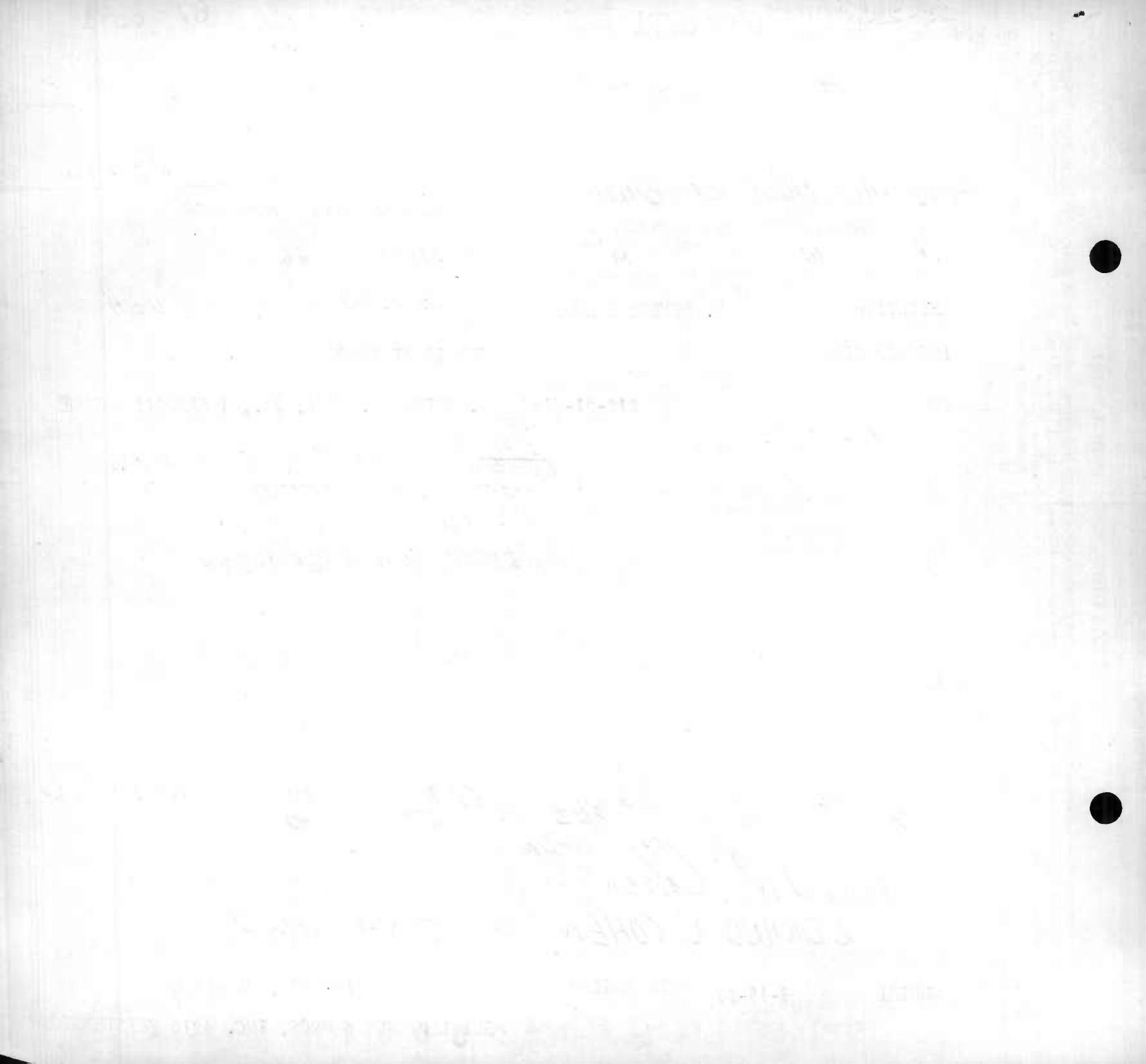
BIRTH NO. 67 8870		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8870	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Paul Frank		2. DATE AND HOUR OF DEATH Sept. 13, 1967 10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 12 Sinai Hospital		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-15 D. STREET ADDRESS (If rural, give location) 4301 Buchanan Ave 21-11			
5. SEX Male	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months Days 10 P.M.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10B. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Aaron Frank		14. MOTHER'S MAIDEN NAME Merel ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-28-6257		17. INFORMANT Mrs Gladys Frank - 4301 Buchanan Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Coronary thrombosis (B) DUE TO Arteriosclerosis (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		MEDICAL CERTIFICATION (Released on Approval)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. DATE OF OPERATION 1966			
22. DATE OF OPERATION 1966		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
31. I certify that (I) (this hospital) attended the deceased from April 27, 1966 to April 27, 1966 and that (I) (we) last saw the deceased alive on April 27, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
32. SIGNATURE Nathan E. Needle		33. DATE SIGNED 9/14/67		34. PHYSICIAN'S NAME (Type) NATHAN E. NEEDLE	
35. ADDRESS 6506 Park Hys Dr		36. DATE 1966		37. NAME OF CEMETERY OR CREMATORY Ohu Knesseth Israel	
38. LOCATION (City, town, or county) (State) Rosedale, Maryland		39. DATE REC'D BY HEALTH DEPT. SEP 18 1967		40. NAME OF REGISTRAR Sal Leunson	
41. FURNERAL DIRECTOR		42. ADDRESS		43. DATE	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 8871	
<div> <div>R-200</div> <div>67 8871</div> <div>CERTIFICATE OF DEATH</div> </div>											
<div> <div>BIRTH NO.</div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED</div> <div>(Type or Print)</div> </div> <div>ARTHUR B. RIES</div>						<div> <div>2. DATE AND HOUR OF DEATH</div> <div>9/13/67 11:04 P.M.</div> </div>					
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> </div> <div>42 SINAI HOSP OF BALTO.</div>						<div> <div>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</div> <div>A. STATE B. COUNTY</div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</div> <div>D. STREET ADDRESS (If rural, give location)</div> </div> <div>MD BALTO Co. BALTO. 53-00 11 SLADE AVE APT 504</div>					
<div>5. SEX</div> <div>M</div>		<div>6. RACE</div> <div>W</div>		<div>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)</div> <div>M</div>		<div>8. DATE OF BIRTH</div> <div>6/29/01</div>		<div>9. AGE (In years last birthday)</div> <div>66</div>		<div>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</div>	
<div>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>EXECUTIVE</div>				<div>10B. KIND OF BUSINESS OR INDUSTRY</div> <div>S. MEYERS & SONS</div>				<div>11. BIRTHPLACE (State or foreign country)</div> <div>BALTO.</div>		<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>	
<div>13. FATHER'S NAME</div> <div>LEOPOLD RIES</div>						<div>14. MOTHER'S MAIDEN NAME</div> <div>JENNIE ATKINSON</div>					
<div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div>NO</div>				<div>16. SOCIAL SECURITY NO.</div> <div>212-01-4138</div>		<div>17. INFORMANT ADDRESS</div> <div>MR. ARTHUR B. RIES, JR., 4 RANDALL AVENUE</div>					
<div>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div>						<div>CAUSE OF DEATH</div> <div>ACUTE</div> <div>(A) DUE TO</div> <div>CHRONIC RENAL FAILURE</div> <div>PROGRESSIVE (UREMIA)</div> <div>ASCVD</div> <div>(B) DUE TO</div> <div>RENOVASCULAR HYPERTENSION</div> <div>(C) DUE TO</div>				<div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>1 YR</div>	
<div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div>											
<div>19A. DATE OF OPERATION</div> <div>0</div>				<div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>				<div>20A. AUTOPSY? (Yes or No)</div>		<div>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>	
<div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</div>				<div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>				<div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div>			
<div>21D. TIME OF INJURY (APPROX.)</div>				<div>21E. INJURY OCCURRED</div> <div>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>				<div>21F. HOW DID INJURY OCCUR?</div>			
<div>22. I certify that (1) (this hospital) attended the deceased from 8/31/67 to 9/13/67, that (2) (we) last saw the deceased alive on 9/13/67 and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.</div>											
<div>23A. SIGNATURE</div> <div>Edward R. Cohen</div> <div>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></div>								<div>23B. DATE SIGNED</div>			
<div>23C. PHYSICIAN'S NAME (Type)</div> <div>EDWARD R. COHEN</div> <div>M.D.</div>								<div>23D. ADDRESS</div> <div>SINAI HOSP</div>			
<div>24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div>				<div>24B. DATE</div> <div>9-15-67</div>		<div>24C. NAME OF CEMETERY or CREMATORY</div> <div>OHEB SHALOM</div>				<div>24D. LOCATION (City, town, or county) (State)</div> <div>BALTIMORE, MARYLAND</div>	
<div>25A. DATE REC'D BY HEALTH DEPT.</div> <div>SEP 18 1967</div>				<div>25B. NAME OF REGISTRAR</div> <div>R. B. E. Taylor</div>				<div>25C. FUNERAL DIRECTOR ADDRESS</div> <div>SOL LEVINSON & BROS, INC. 6010 REISTERSTOWN RD</div>			



FUNERAL DIRECTOR: IMPORTANT

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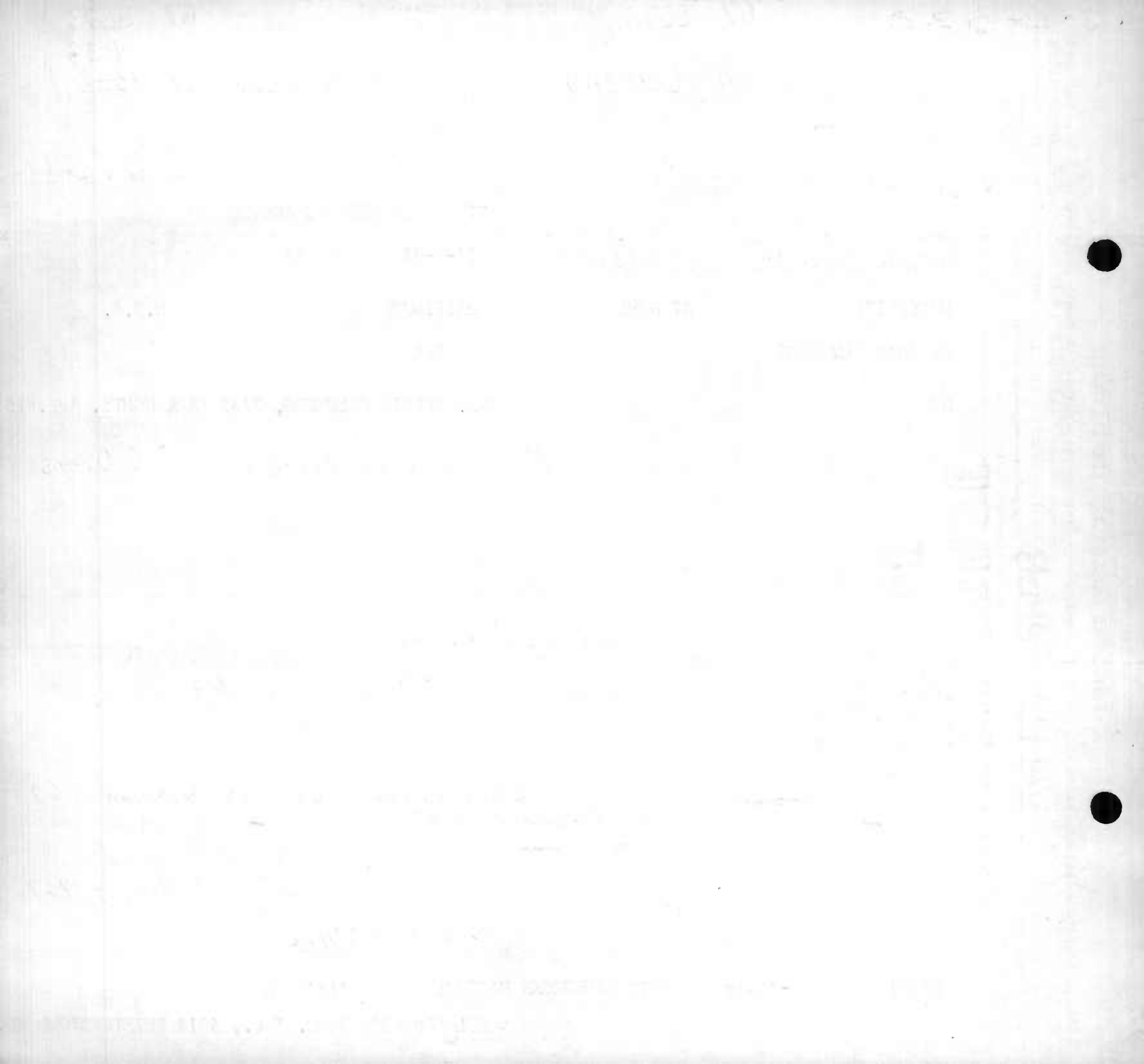
BIRTH NO. 67 8872		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8872	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Louis Sydney</i>		2. DATE AND HOUR OF DEATH <i>September 14/67 6 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-18</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Paul Moele Nursing Home</i> <i>4600 Paul Moele Rd</i>		D. STREET ADDRESS (If rural, give location) <i>5412 Bruce Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widower</i>	8. DATE OF BIRTH <i>8-2</i>	9. AGE (In years lost birthday) <i>82</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Proprietor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Grocery Store</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Isaiah Sydney</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Cutter</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Dr Elmer L. Sydney - 3413 oed Ct Rd</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>163XV-260X</i> CAUSE OF DEATH <i>Carcinoma of Lung</i> (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>About 1 year</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>		19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19 62</i> to <i>Sept 14 19 67</i> , that (I) (we) last saw the deceased alive on <i>9/14/67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Julius C. Gluck</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>JULIUS C. GLUCK</i>		M.D. 23D. ADDRESS <i>5356 Retterdale Road</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>Sept 15/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Lincoln</i>	
24D. LOCATION (City, town, or county) (State) <i>Providence, Rhode Island</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 18 1967</i>		25B. NAME OF REGISTRAR <i>Dr. G. E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>Dr. Johnson</i>		25D. ADDRESS <i>6010 Retter Rd.</i>			



FUNERAL DIRECTOR: IMPORTANT

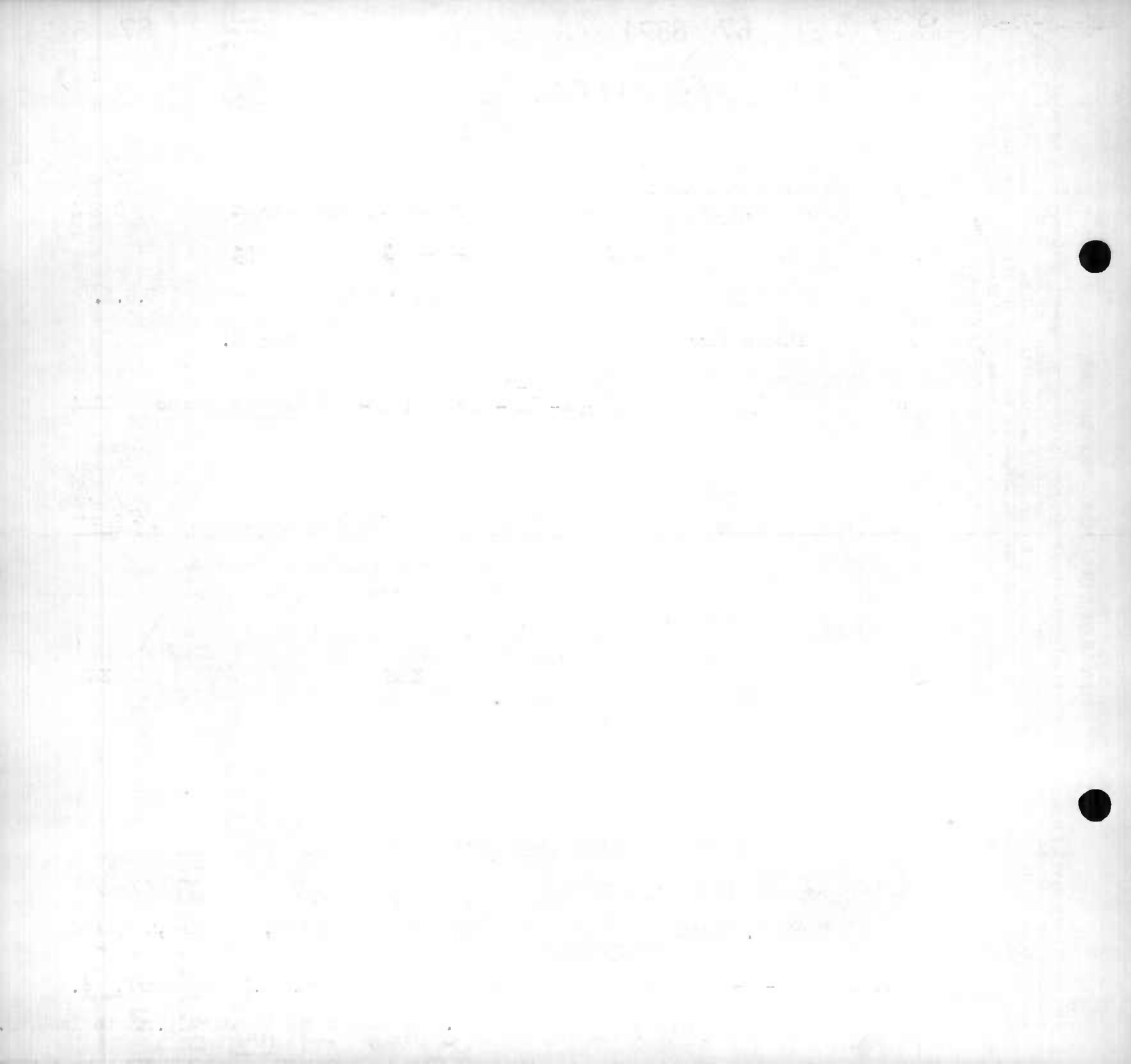
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8873	
BIRTH NO. 67 8873		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BERTHA LUTZKY		2. DATE AND HOUR OF DEATH 14 SEPTEMBER 1967 1:33 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		A. STATE MARYLAND B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 7126 PARK HEIGHTS AVENUE			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 11-6-97	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ABRAHAM BLUMBERG		14. MOTHER'S MAIDEN NAME IDA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. MELVIN GOLDBERG, 7162 PARK HIGHTS. AVE. #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 A-260X		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) ASHD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 8 SEPTEMBER 1967 to 14 SEPTEMBER 1967 , that (I) we last saw the deceased alive on 14 SEPTEMBER 1967 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) did not view the body after death.					
23A. SIGNATURE Richard N. Katon M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 14 August 1967	
23C. PHYSICIAN'S NAME (Type) RICHARD N. KATON		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-15-67		24C. NAME of CEMETERY or CREMATORY BETH HAMEDROSH HAGDOL	
24D. LOCATION BALTIMORE		24E. DATE REC'D BY HEALTH DEPT. SEP 18 1967			
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR ADDRESS SOL LEVINSON BROS. INC., 6010 REISTERSTOWN RD.			



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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8874	
5-436		67 8874		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
ELLIA		SHOWALTER		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		B. COUNTY	
Baltimore City Hospitals		Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
4940 Eastern Avenue		Baltimore		D. STREET ADDRESS (If rural, give location)	
Baltimore, Maryland 21224		900 South Ponca Street		21224	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED, DIVORCED (specify)	12-14-1883	83	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Widowed		West Virginia		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas Carr			Mary E.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. -T		
No			212-24-0192		
17. INFORMANT			ADDRESS		
Records: BCM-4940 Eastern Avenue			21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			2 days		
ANTECEDENT CAUSES			1 yr		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			5 yrs		
II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
Urinary Tract Infection					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
22		YES	YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (1) (this hospital) attended the deceased from 9/1/67 to 9/14/67, that (1) (we) last saw the deceased alive on 9/14/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
David E. McBeth				9/14/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
David E. McBeth				4940 Eastern Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	9-17-67	Zion Memorial Park	Bedford Rd., Cumberland, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
SEP 18 1967	Robert E. Taylor	H. Lee Silcox 404 Decatur St., Cumberland, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underlying disease; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8875					Registered No. 67 8875				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) JOSEPH C. LEARY					2. DATE AND HOUR OF DEATH 9-14-67 9:58AM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
D. STREET ADDRESS (If rural, give location) 2631 HUDSON STREET					E. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-6-02		9. AGE (In years lost birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME HAMILTON LEARY					14. MOTHER'S MAIDEN NAME MARTHA VEST				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI					16. SOCIAL SECURITY NO. 235-14-2297				
17. INFORMANT (Name) Mrs. Ethel Leary					ADDRESS Md. 21224 2631 Hudson St. Balto.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBROVASCULAR Acc.					INTERVAL BETWEEN ONSET AND DEATH 2 WKS				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MALIGNANT HYPERTENSION					2 MONTHS				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC PYELONEPHRITIS					YEARS				
19A. DATE OF OPERATION 8-29					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES				
20A. AUTOPSY? (Yes or No) YES					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) JOHNS HOPKINS HOSP.				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (the hospital) attended the deceased from 8-29 19 67 to 9-14 19 67 , that (I) (we) last saw the deceased alive on 9-15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Major Bradshaw					23B. DATE SIGNED 9-14-67				
23C. PHYSICIAN'S NAME (Type) MAJOR BRADSHAW					23D. ADDRESS JOHNS HOPKINS HOSP.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 9/18/67				
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967					25B. NAME OF REGISTRAR John J. Duda, Inc.				
25C. FUNERAL DIRECTOR John J. Duda, Inc.					ADDRESS 2829 Hudson St. Balto. Md.				

1. General Information
 2. History of the Project
 3. Objectives and Scope
 4. Methodology
 5. Results and Discussion
 6. Conclusion
 7. References
 8. Appendices
 9. Index
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James Thompson's book

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1034

1034 E. Kray

12th

1034 E. Kray
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1034 E. Kray

1034 E. Kray

1034 E. Kray

1034 E. Kray

Multiple Myeloma

1034 E. Kray

1034 E. Kray

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1034 E. Kray

1034 E. Kray

1034 E. Kray

1034 E. Kray

1034 E. Kray

Caroline Tillman
1840
at Dover

John L. Thompson

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 8878

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED **NORMAN**
(Type or Print)**REV. NORMAL D. MARKS SR.**

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1967 | **5:45 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

2121**Balti. Co.**

D. STREET ADDRESS (If rural, give location)

1633 Williams Ave.FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)**9-20-67****City Hospital D.O.A.**

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Married**

8. DATE OF BIRTH

March 14, 18999. AGE (In years
last birthday)**68**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Ret. Projectionist**

10B. KIND OF BUSINESS OR INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

Maryland12. CITIZEN OF
WHAT COUNTRY?**U. S.A.**

13. FATHER'S NAME

Harry Marks

14. MOTHER'S MAIDEN NAME

Louise ?15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**Yes****W Ww1**16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

2121**Mrs. Evelyn Mathews Marks 1633 William Ave.**

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Arteriosclerotic Cardiovascular
Disease**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO(C)
DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)**Russell S. Fisher, M.D.**

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

9/19/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

21225**SEP 18 1967****Robert E. Fisher****McCully Funeral Home****237 Patapsco Ave.**

VALLEY FORCE
DEPARTMENT

Success

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8878		67 8878		67 8878	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William J. Wengert, Jr.		9-14-1967 9:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
South Baltimore General Hosp Baltimore, Md. 21230		Maryland			
5. SEX M		6. RACE White			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH			
Married		3-30-12			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)			
Inspector		Baltimore, Md.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William J. Wengert, Sr.		Carrie Boston			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Dorothy F. Wengert	
				ADDRESS 1328 Webster St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 I		PROGRESSIVE			
ANTECEDENT CAUSES		(A) GANGRENE OF RIGHT PELVIC AREA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
II		(B) ARTERIOSCLEROTIC CARDIOVASCULAR			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 8-15 1967 to 9-14 1967, that (we) last saw the deceased alive on 9-14 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Larry J. Warner				23B. DATE SIGNED 9-14-67	
23C. PHYSICIAN'S NAME (Type) Larry J. Warner				23D. ADDRESS South Baltimore General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/18/67		Cedar Hill Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 18 1967		Robert E. Jackson		McCully Funeral Home	
				ADDRESS 130 E. Fort Ave.	

گودون ایس. الیوت

72 51 47.5 1

Mrs Dorothy F. Wenzel

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 03-22-2007 BY 60322 JAL/STW

Harold Hoover

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ADAM E.

UPMAN

2. DATE AND HOUR PRONOUNCED DEAD

September 13, 1967 4:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF DECEASED (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
 4-20-67
 40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

HOWARD CO

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore ELLICOTT CITY 63-00

D. STREET ADDRESS (If rural, give location)

RFD 2 - Old Frederick Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11/18/12

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

EDWARD UPMAN

14. MOTHER'S MAIDEN NAME

MARY RAUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

219-059-242

17. INFORMANT

FENEVIEVE UPMAN

ADDRESS

18. 331 X

219-059-242

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Spontaneous Cerebral Hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

ii
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/16/67

23C. NAME of CEMETERY or CREMATORY

CREST LAWN

23D. LOCATION

(City, town, or county)

(State)

HOWARD CO, MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 18 1967

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

F. S. MACNAB

ADDRESS

301 FREDERICK RD
21228

WALSH FORCE

11/18/67

11/18/67

11/18/67

11/18/67

11/18/67

11/18/67

11/18/67

11/18/67

11/18/67

11/18/67

11/18/67

W-343

67 8881 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8881

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FLOYD

WHITELEATHER

2. DATE AND HOUR PRONOUNCED DEAD

September 15, 1967 6:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6420 ~~Kriell Avenue~~ Kriell Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 10, 06

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Special Purchase

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore Fed.

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Mark Whiteleather

14. MOTHER'S MAIDEN NAME

Carrie Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

145-10-0223

17. INFORMANT

ADDRESS

Margaret Whiteleather Same as # 4

18.

422.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/18/67

23C. NAME of CEMETERY or CREMATORY

Woodlawn

23D. LOCATION

(City, town, or county)

(State)

Woodlawn Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 18 1967

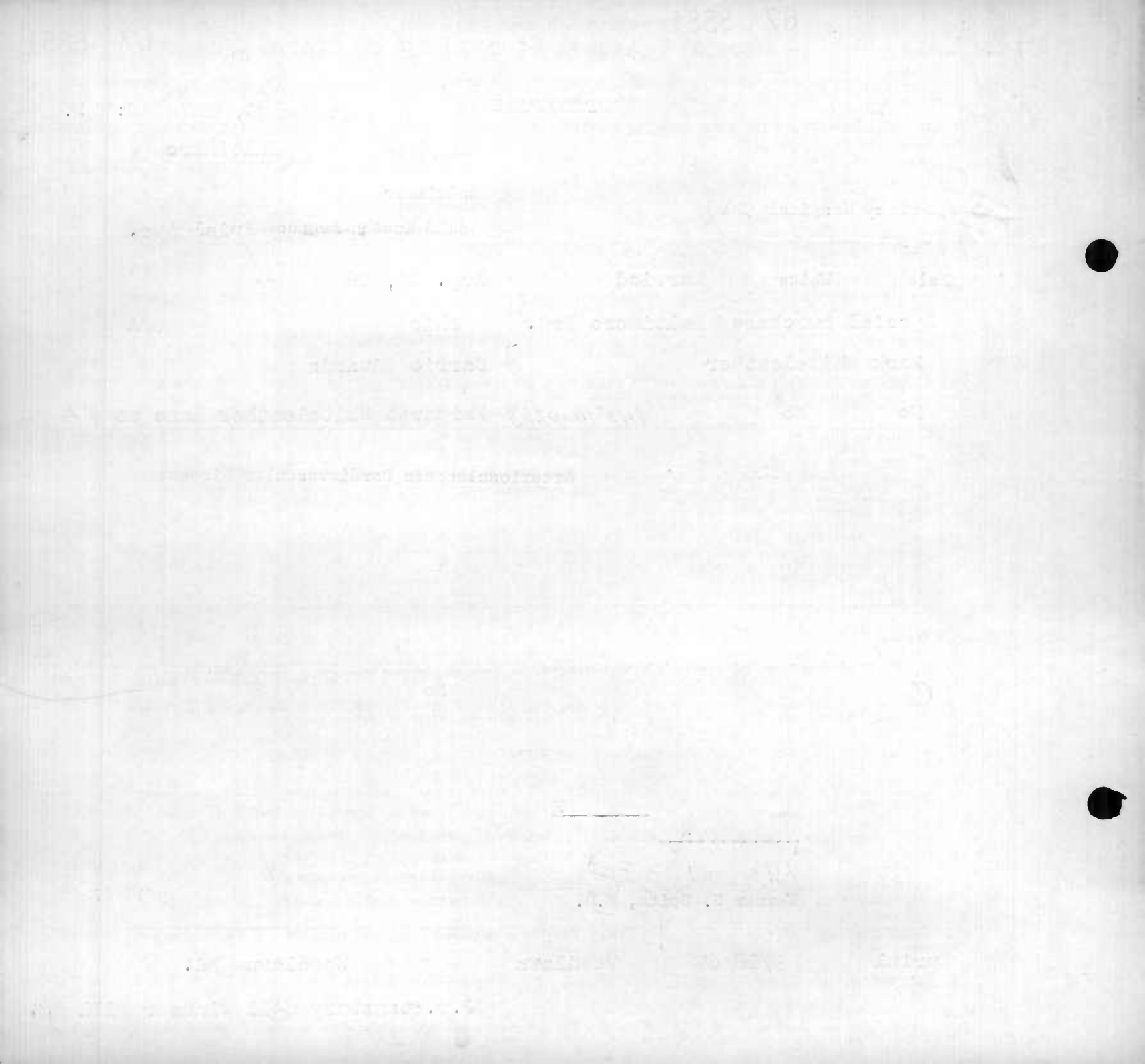
24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

J.T. Stansbury 6411 Windsor Mill Rd.

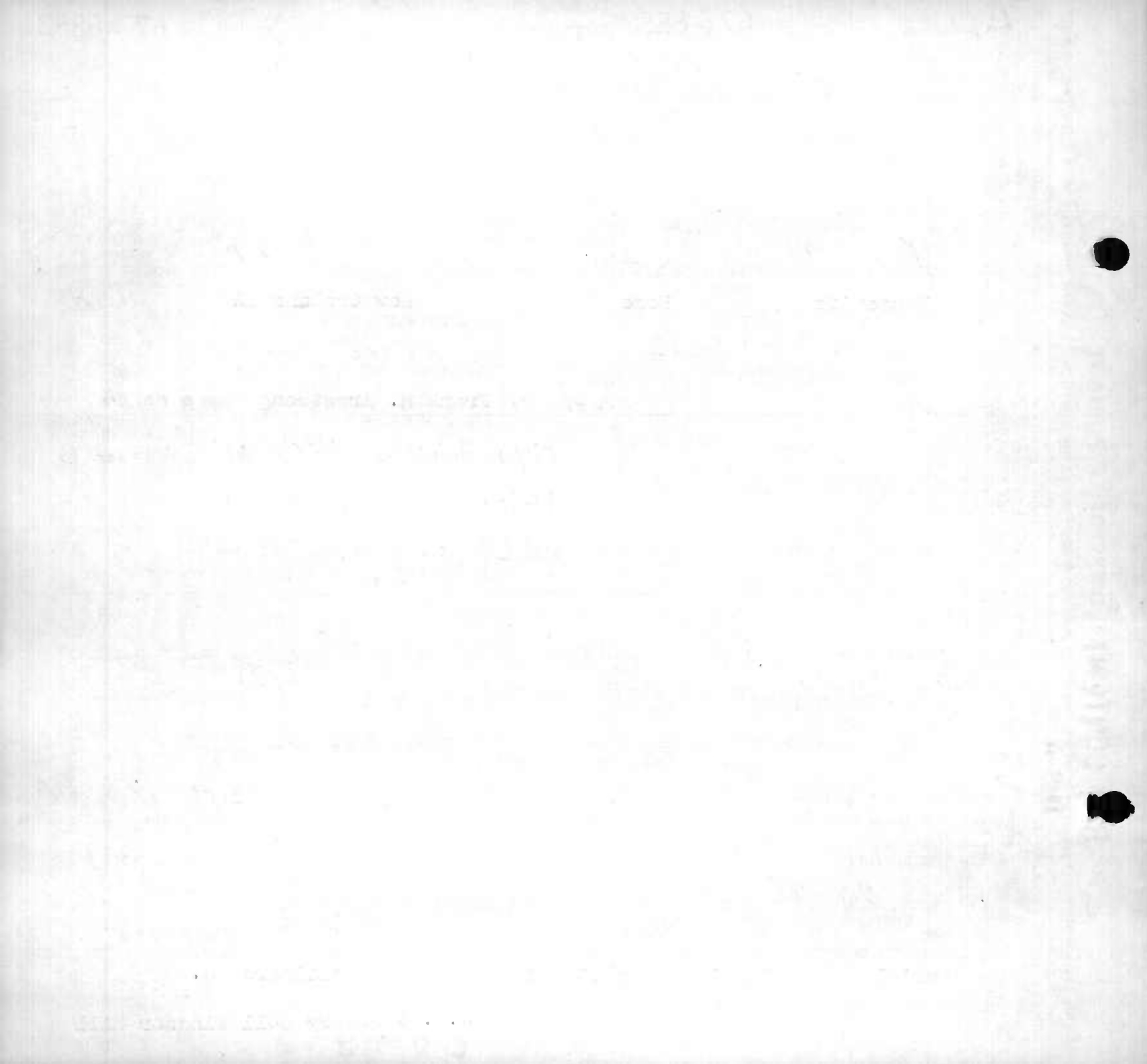
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

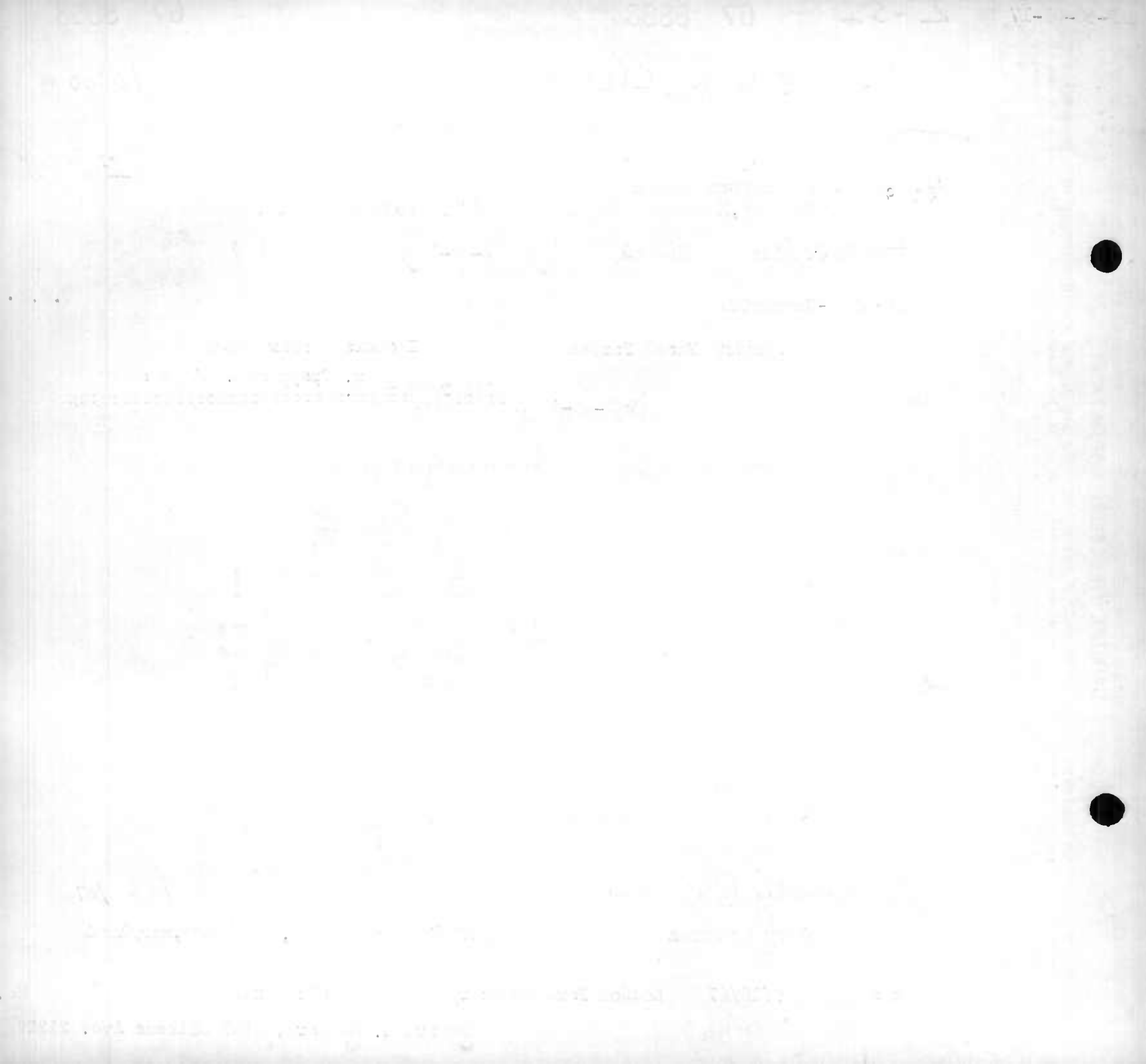
BIRTH NO. 67 8882		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8882	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ABBIE R. ARMSTEONG		2. DATE AND HOUR OF DEATH 9-16-67 ¹⁵⁵ P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 2024 RUSSELL AVE.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 10-31-77	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) New Orleans LA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FRANK RICHMOND		14. MOTHER'S MAIDEN NAME GRACE WANTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-48-2138		17. INFORMANT ADDRESS Frank R. Armstrong Same as #4	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCT (A) DUE TO ARONARY OCCUSION (B) DUE TO ARTEROSCLEROTIC HEART DISEASE. (C)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 10-14 D	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/25/1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED serious		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 25 1967 to Sept 16 1967 , that (I) (we) lost saw the deceased alive on Sept 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Youngsik Moon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept 16, 1967	
23C. PHYSICIAN'S NAME (Type) Youngsik Moon		23D. ADDRESS Maryland Gen. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/67		24C. NAME OF CEMETERY or CREMATORY Baltimore	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE RECEIVED BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR ADDRESS J.T. Stansbury 6411 Windsor Mill	



BIRTH NO. 67 8883		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8883	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LINGEMAN, LILLIAN W		2. DATE AND HOUR OF DEATH 9/13/67 10:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-08	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location) 4213 Potter Street, 21229			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 2-18-1899	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Pardoe		14. MOTHER'S MAIDEN NAME Isadora Lowe	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-4867D		17. INFORMANT Mr. Francis X. Lingeman 4213 Potter Street, 21229 Baltimore, Md 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 223X1 Meningioma		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Decubitus ulcers			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8/25 19 67 to 9/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Zachary Grossman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/13/67	
23C. PHYSICIAN'S NAME (Type) Zachary Grossman		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md					
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8884		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8884	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WALSH, JACK VERNON JOHN F.		2. DATE AND HOUR OF DEATH 9:50 SEPTEMBER 12, 1967 9:49 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229		A. STATE MARYLAND 21229 B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 1116 VERNON AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/28/22	9. AGE (In years lost birthday) 45	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED		10B. KIND OF BUSINESS OR INDUSTRY DISABLED		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANCIS WALSH		14. MOTHER'S MAIDEN NAME MARGARET (MC LAUGHLIN) WALSH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS CATON AND WILKENS AVE. 21229 HOSPITAL RECORDS- ST. AGNES HOSPITAL-	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH Emphysema			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost.		(B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from AUGUST 25, 19 67 to SEPTEMBER 12, 19 67, that (X) (we) last saw the deceased alive on SEPTEMBER 12, 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE Carolyn Pass		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-12-67	
23C. PHYSICIAN'S NAME (Type) CAROLYN PASS		23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore		24E. ADDRESS Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

67-817-111

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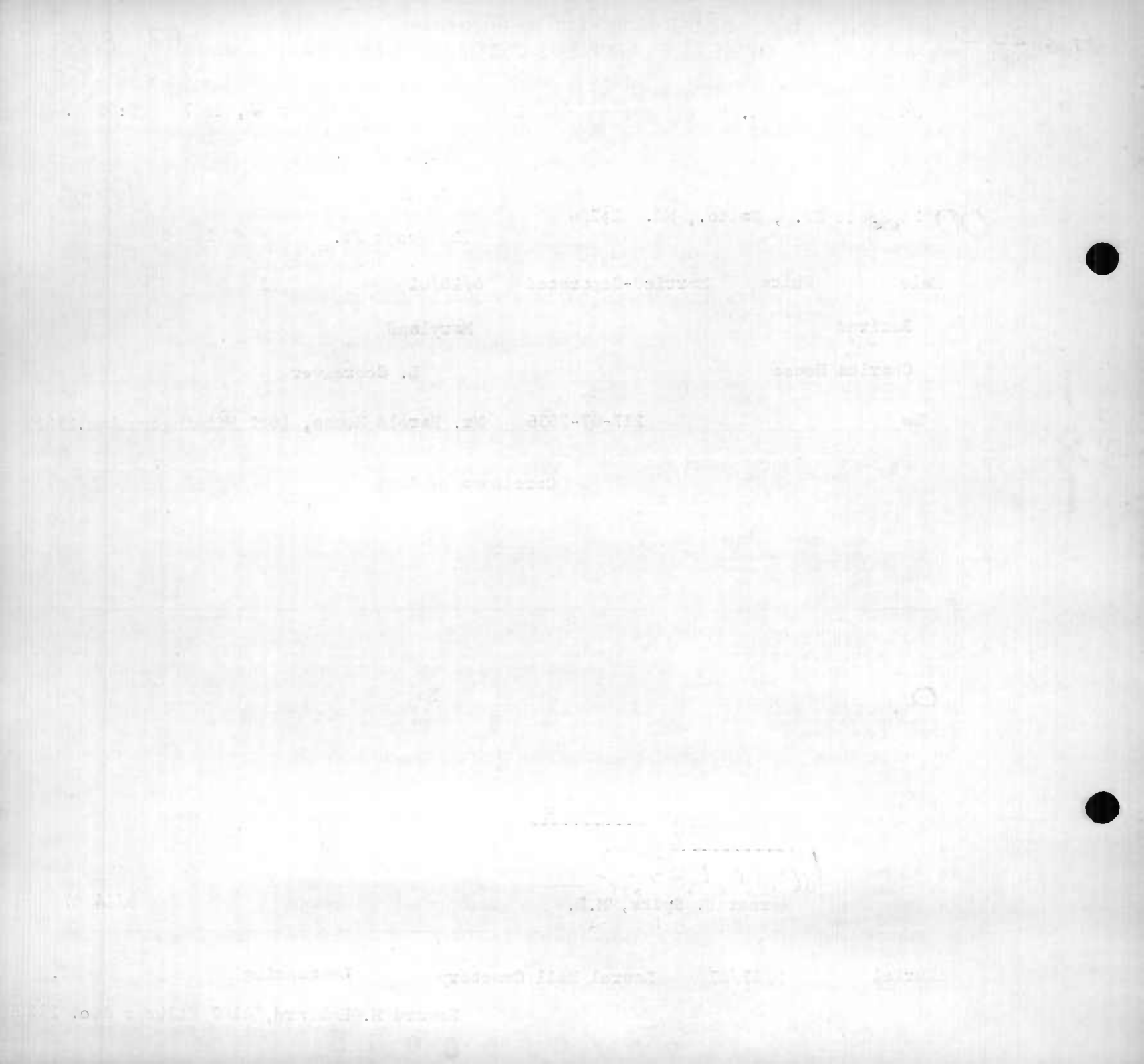
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67 8885 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8885

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) JOHN W. HOUSE		2. DATE AND HOUR PRONOUNCED DEAD September 14, 1967 9:05 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 321 Scott St., Balto., Md. 21230		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 21-01 D. STREET ADDRESS (If rural, give location) 321 Scott St. 21230	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married-Separated	8. DATE OF BIRTH 6/28/02
9. AGE (In years last birthday) 65		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles House		14. MOTHER'S MAIDEN NAME L. Schreiber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-2036	
17. INFORMANT Mr. Harold House, 1022 Wilmington Ave. 21223		ADDRESS	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Carcinoma of Lung DUE TO (B) DUE TO (C)	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/14/67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9/17/67	
23C. NAME of CEMETERY or CREMATORY Laurel Hill Cemetery		23D. LOCATION (City, town, or county) (State) Lonaconing Md.	
24A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		24B. NAME OF REGISTRAR R. E. Fairbank	
24C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



1
S-530

67 8886

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8886

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

C.

ALTON SMITH

2. DATE AND HOUR PRONOUNCED DEAD

September 13, 1967 2:27 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1842 E. 28th Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 19, 1947

9. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wilson, N. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Nathaniel H. Smith

14. MOTHER'S MAIDEN NAME

Lavenia Battle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-44-2587

17. INFORMANT

ADDRESS

Lavenia S. Gardner - 1842 E. 28th St.

18. E 781 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Front of 3301 Elgin St. 15-47

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 13 67 2:00

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject shot during attempted robbery

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-18-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 18 1967

R. S. Fisher, M.D.

Charles R. Law 802 Madison Ave.

N 85-61-467000089006

RECEIVED
JAN 10 1964
FBI - NEW YORK

TO : DIRECTOR, FBI (100-374301)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[Illegible text block containing several lines of typed information, possibly a memorandum or report.]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

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B-570

67 8887

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8887

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FLORENCE

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1967 8:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BENBOW

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland
B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1711 W. Baltimore St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1711 W. Baltimore St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

March 15, 1898

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Santee, S. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Josah Green

14. MOTHER'S MAIDEN NAME

Amanda Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Robert Epps - 1122 Kevin Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Stomach
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

9/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-19-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

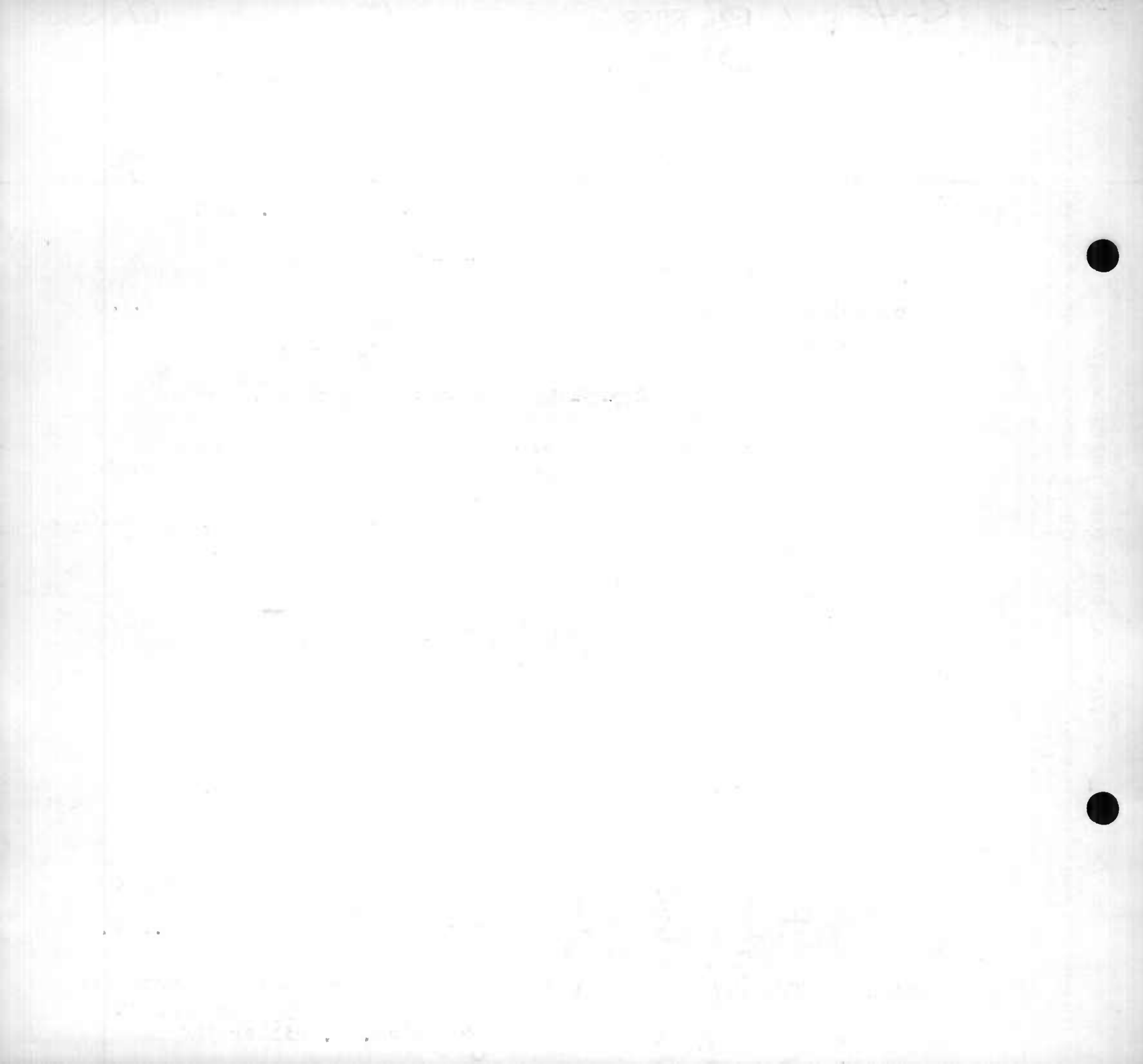
SEP 18 1967

Philip E. Farber, M.D.

Charles R. Law 802 Madison Ave.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8888	
C-453 67 8888		BIRTH NO.			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CARRIE CALLENDER			
2. DATE AND HOUR OF DEATH 12:30 AM 9/5/67		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 2-11-86		9. AGE (In years last birthday) 81		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Henry Seitz		14. MOTHER'S MAIDEN NAME Susie Turner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-22-2632		17. INFORMANT 4940 Eastern Avenue Records: BCH Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic renal insufficiency - 2° to chronic pyelonephritis & nephrosclerosis Diabetic Mellitus 2° ASCVD, cerebrovascular disease, chronic CHF sebs		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH uncertain	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hyperfunctioning gite - retained adipose tissue gite dysfunction - ?		uncertain uncertain uncertain	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/18 19 67 to 9/5 19 67 , and that (I) (we) last saw the deceased alive on 9/4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Leonard Lippman		23B. DATE SIGNED 9/5/67	
23C. PHYSICIAN'S NAME (Type) LEONARD LIPPMAN		23D. ADDRESS 4940 Eastern Avenue BALT. CITY 14051 Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/67		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION (City, town, or county) Greenmount & North Ave		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Frederick D. Miller Inc		25C. FUNERAL DIRECTOR 3019 Mounment St Frederick, D. Miller Inc	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400 67 8889		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8889	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARGARET A. BEALL		SEPT 14, 1967		1:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		A. STATE MARYLAND		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		5418 ST. ALBANS WAY	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/14/10	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
		10B. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM ASHTON		14. MOTHER'S MAIDEN NAME LUCY JOHANSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Franklin M. Beall-5418 St. Albans Way	
18. 445X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) Malignant nephrosclerosis DUE TO (C) W.B. Wa		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/17 19 67 to 9/14 19 67, that (I) lost saw the deceased alive on 9/13 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE W. H. Oehlert, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/14/67	
23C. PHYSICIAN'S NAME (Type) W. H. OEHLERT, JR.		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/16/67	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sterling Funeral Estate of Catonsville - 736 Edmondson Ave.	

W. H. Galt

2nd 14 1901

W. H. Galt

Baltimore

2418 St. Johns Way

2418 St. Johns Way

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

W. H. Galt

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8890				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8890	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALVIN WELSH ALVIN BERNARD WELSH				2. DATE AND HOUR OF DEATH SEPT. 17, 1967 2:15 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 3 SOUTH BALTO. GENERAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1821 S. Charles St. 21230			
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH July 5, 1921	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper			10B. KIND OF BUSINESS OR INDUSTRY B & O R. R. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Peter Joseph Welsh				14. MOTHER'S MAIDEN NAME Myrtle Carmine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. 2			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Ethel Welsh 1821 S. Charles St. 21230		
18. 144X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SQUAMOUS CELL CARCINOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OF BUCCAL MUCOSA WITH WIDE SPREAD TO CERVICAL STRUCTURES				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-9 19 67 to 9-17 19 67 , that (I) (we) last saw the deceased alive on 9-17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Larry J. Warner				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 17, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. 1213 Light St. Balto. Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/67		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 130 W. Fort Ave. 21230	

FOR THE BATTLE OF BULGE

10

SEPARATE CELL CARCINOMA
OF BUCAL MUCOSA WITH WIDE
SPREAD TO CERVICAL STRUCTURES

P-11 P-11 P-11 P-11 P-11

Land of Honor

1
R-326

67 8891 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 8891

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EUGENE L. RODGERS Rodgers

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1967 8:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2022 Harman Ave. Morrell Park

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2022 Harman Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

5/7/13

9. AGE (In years
last birthday)

54 59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Wholesale Newspaper Dealer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John H. Rodgers

14. MOTHER'S MAIDEN NAME

Clara Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-10-4039

17. INFORMANT

ADDRESS

Mrs. Erma D. Rodgers, 2022 Harman Ave. 21230

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

September 15, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/18/67

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 18 1967

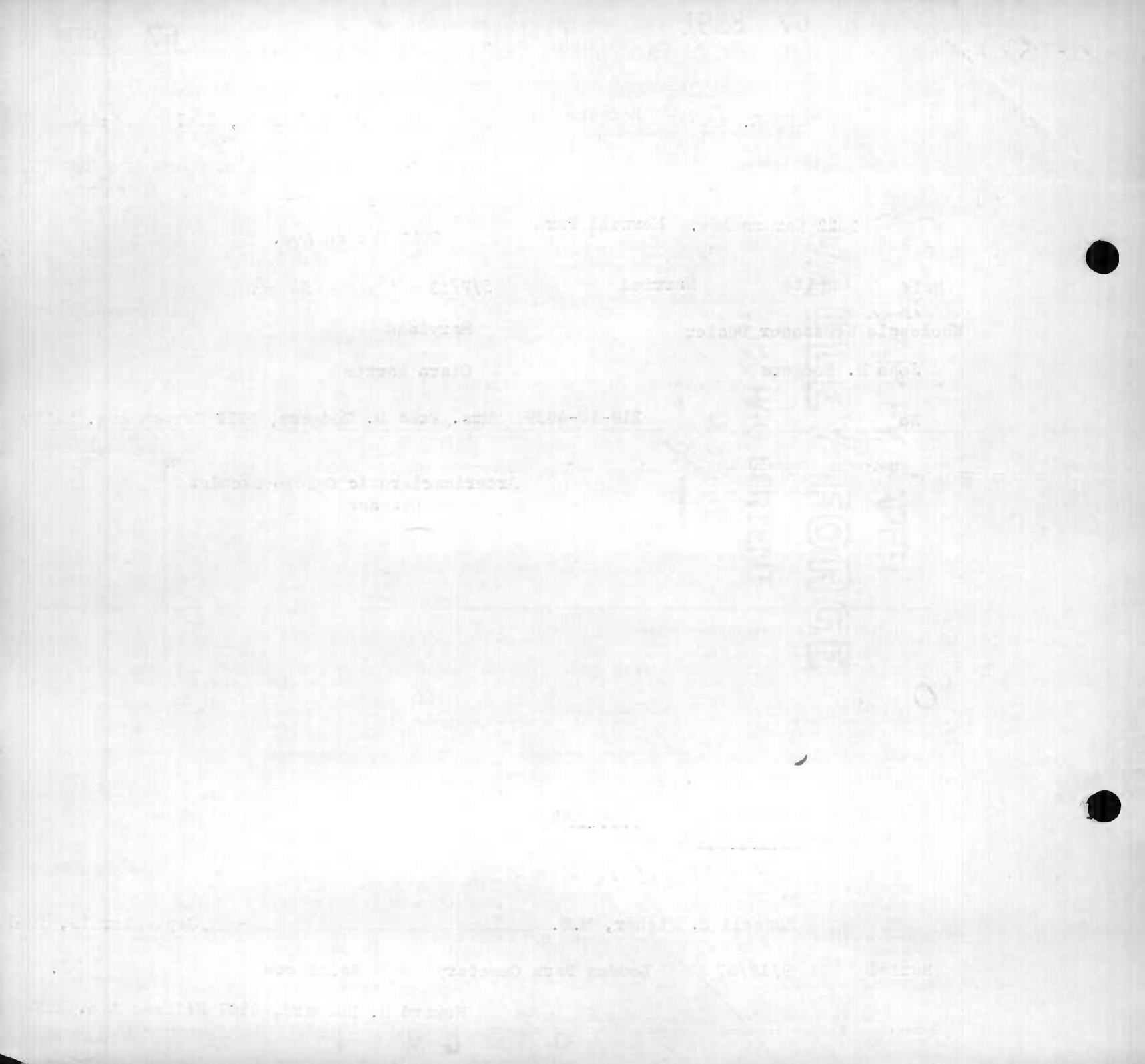
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

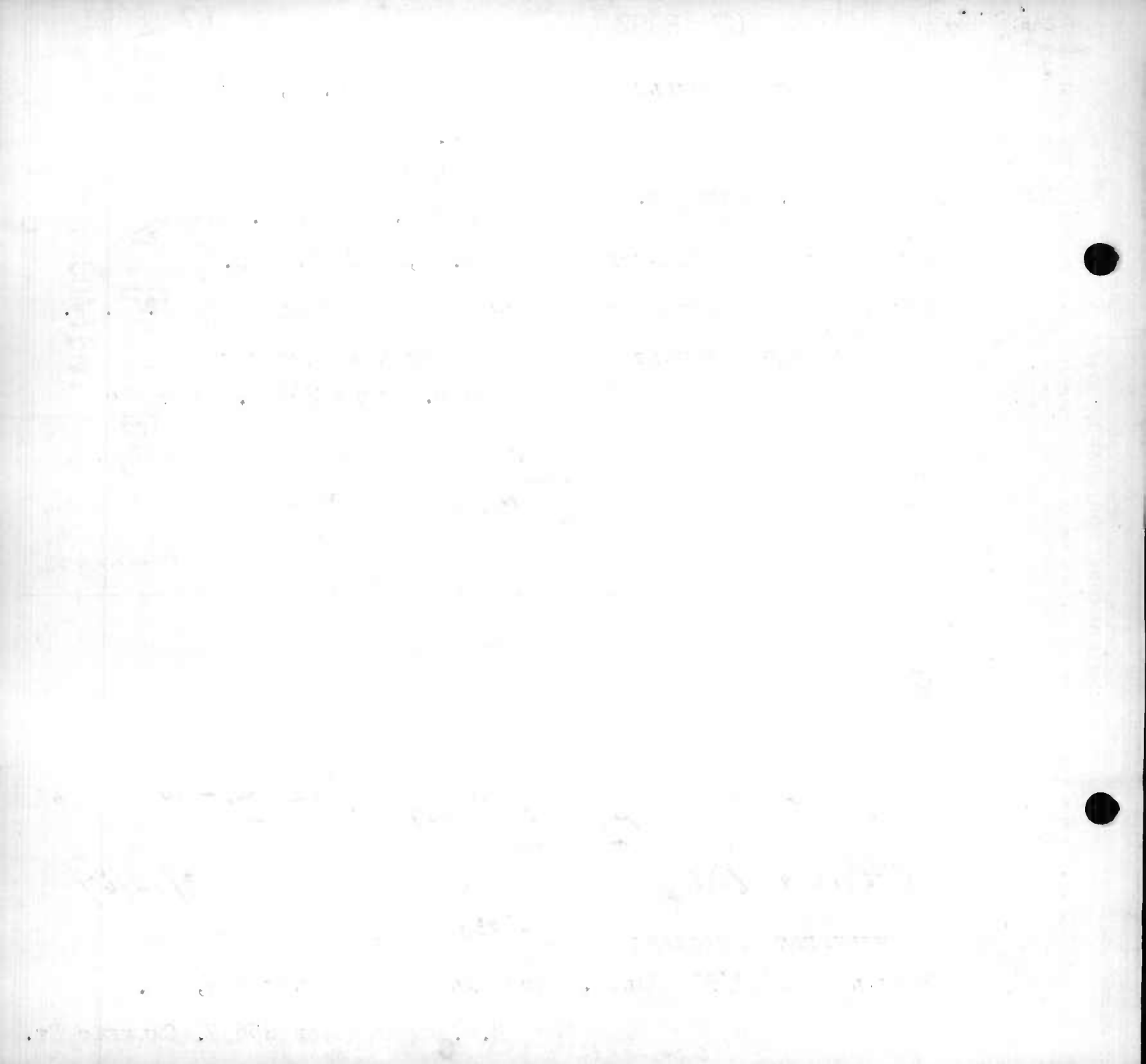
Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

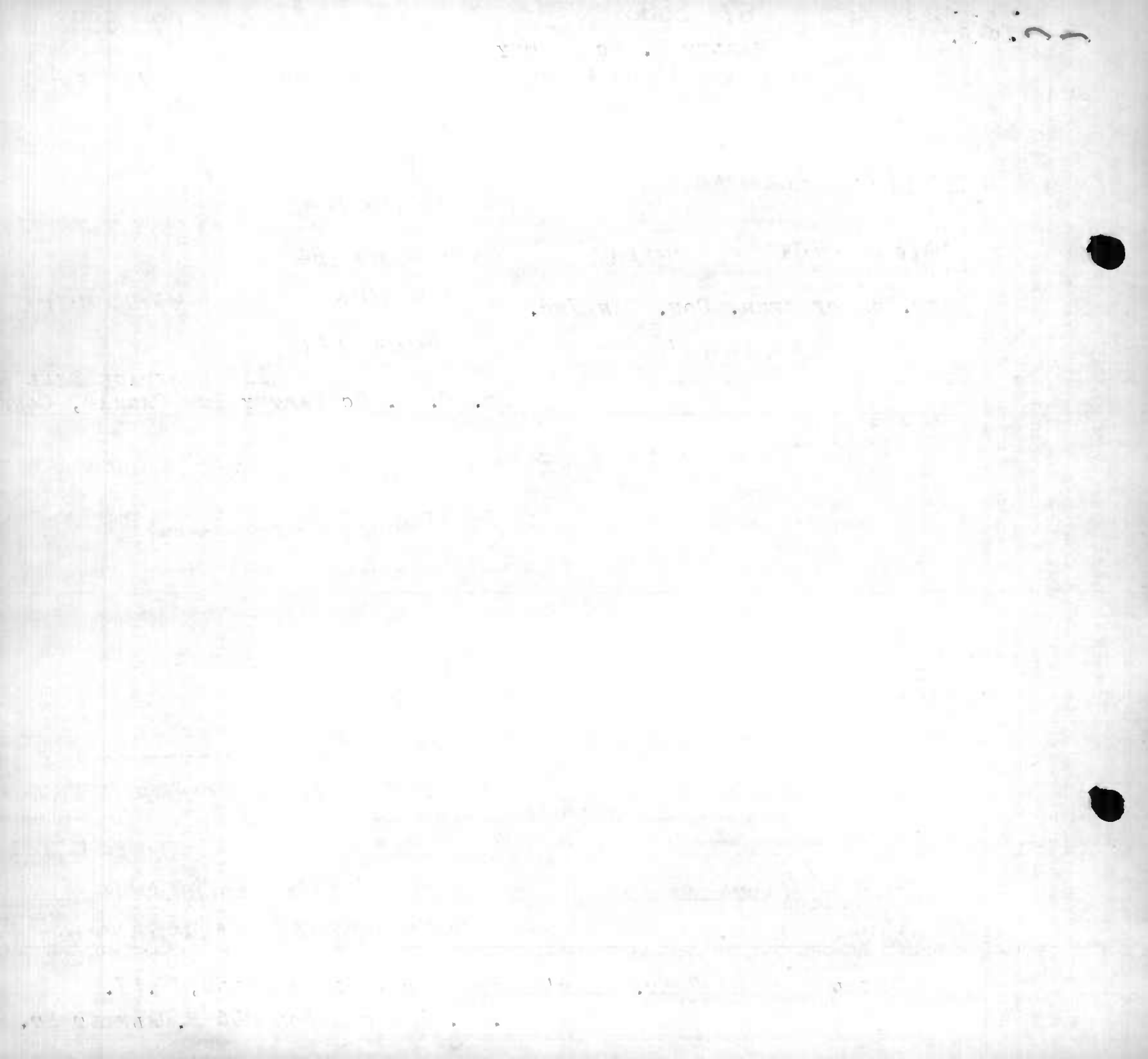
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8892	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED <small>(Type or Print)</small> ANDREW BECHELLI		2. DATE AND HOUR OF DEATH SEPT. 14, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <small>(If not in hospital or institution, give street address or location)</small> 00 206 E. EAGER ST.		4. USUAL RESIDENCE <small>(Where deceased lived. If institution: residence before admission)</small> A. STATE Md. B. COUNTY C. CITY OR TOWN <small>(If outside city limits, write RURAL and give township)</small> BALTIMORE D. STREET ADDRESS <small>(If rural, give location)</small> 206 E. EAGER ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <small>(specify)</small> MARRIED	8. DATE OF BIRTH DEC. 25, 1893	9. AGE <small>(In years last birthday)</small> 73 YRS.	10. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> RETIRED
10A. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> RETIRED		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT BUSINESS		11. BIRTHPLACE <small>(State or foreign country)</small> ITALY	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME DIMETRO BECHELLI		14. MOTHER'S MAIDEN NAME CECELIA CEECHINI			
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small>		16. SOCIAL SECURITY NO.	17. INFORMANT ROBT. PAYNE ADDRESS 206 E. EAGER ST		
18. CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cerebral Thrombosis (B) DUE TO Myocardial Damage (C) DUE TO Arteriosclerosis - junction of aorta		INTERVAL BETWEEN ONSET AND DEATH 2 hours unknown Unknown	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? <small>(Yes or No)</small>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(notify medical examiner)</small>		21B. PLACE OF INJURY <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small>		21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small>	
21D. TIME OF INJURY <small>(Month) (Day) (Year) (Hour)</small> (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from May 1962 to Sept. 14, 1967 that (I) (we) last saw the deceased alive on Sept. 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Philibert Artigiani M.D.				23B. DATE SIGNED 9/14/67	
23C. PHYSICIAN'S NAME <small>(Typo)</small> PHILIBERT ARTIGIANI				23D. ADDRESS 2305 Mayfield Ave. Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL <small>(Specify)</small> BURIAL		24B. DATE 9/18/67		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL	
24D. LOCATION <small>(City, town, or county)</small> BALTIMORE, MD.		24E. LOCATION <small>(State)</small>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR SEP 18 1967		25C. FUNERAL DIRECTOR H. W. MEARS & SON ADDRESS 805 N. CALVERT ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>263</u>		67 8893		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 8893</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>CHARLES M. MC CARTHY</u>				2. DATE AND HOUR OF DEATH <u>9-15-67</u> <u>12:30 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>CONNECTICUT</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>STAMFORD</u> <u>V-06</u>			
				D. STREET ADDRESS (If rural, give location) <u>RED FOX ROAD</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JANUARY 25, 1903</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GEN. MGR OF MFG. CON. CAN INC.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>JOHN MC CARTHY</u>				14. MOTHER'S MAIDEN NAME <u>ANNA LEE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. C. M. MC CARTHY NEW CANAAN, CONN</u>			
18. <u>331X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>POSSIBLY A NEW MYOCARDIAL INFARCTION OR EXTENSION OF CVA</u> DUE TO (B) <u>CEREBRO-VASCULAR ACCIDENT and ACUTE MYOCARDIAL INFARCTION</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 30</u> 19 <u>67</u> to <u>SEPTEMBER 15</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>SEPTEMBER 15</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Bayani L. Manalo</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>SEPTEMBER 15, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>BAYANI L. MANALO</u>		23D. ADDRESS M.D. <u>MERCY HOSPITAL, BALTIMORE, MARYLAND 21202</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/20/67</u>		24C. NAME of CEMETERY or CREMATORY <u>ST. MARY'S CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>GLENS FALLS, N. Y.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 18 1967</u>		25B. NAME OF REGISTRAR <u>R. L. E. Fajana</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H. W. MEARS & SON 805 N. CALVERT ST.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8894	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 8894 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) TUCKER, HELEN EDNA			2. DATE AND HOUR OF DEATH XO SEPT 15, 1967 8:40PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229 </div> <div style="flex: 1; font-size: small;"> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY _____ 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE (21230) 25-33 6. STREET ADDRESS (If rural, give location) 2709 MAISEL ST.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-23-94	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME GEORGE EDER		
14. MOTHER'S MAIDEN NAME ROSE Krizer			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 214-30-1407		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X1 CAUSE OF DEATH Post Myocardial infarct. Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 13 1967 to SEPTEMBER 15 1967 , that (I) (we) last saw the deceased alive on SEPTEMBER 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE GEORGE ANGOV			23B. DATE SIGNED 9-15-67		23C. PHYSICIAN'S NAME (Type) <i>L. George Angov</i>
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-19-67		24C. NAME OF CEMETERY or CREMATORY St. Mary's Cemetery
24D. LOCATION (City, town, or county) (State) Hampden, Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. 67 8895		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8895	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALVIRA B. EVANS		2. DATE AND HOUR OF DEATH 9-15-67 11:54 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital 1940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23-43 D. STREET ADDRESS (If rural, give location) 1601 Seyton St			
5. SEX ♀	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-14-89	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Emma Gore	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 212-12-7381		17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS ADDRESS 4940 EASTERN AVENUE	
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Respiratory Arrest (B) Pneumonia (C)		INTERVAL BETWEEN ONSET AND DEATH 20 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-1 19 67 to 9-15 19 67, that (I) (we) last saw the deceased alive on 9-15 19 67 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Cordes		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-16-67	
23C. PHYSICIAN'S NAME (Type) ROBERT A. CORDES		23D. ADDRESS 4940 EASTERN AVENUE BALTIMORE CITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-19-1967		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8896		BALTIMORE DEPARTMENT		Registered No. 67 8896	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Margaret Crawford		2. DATE AND HOUR OF DEATH Sept. 15, 1967 8:15 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 19 E. Randall Street		D. STREET ADDRESS (If rural, give location) 19 E. Randall		23-02	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3/22/1884	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lasper Lasper Peters		14. MOTHER'S MAIDEN NAME Margaret Phifer		17. INFORMANT Wm. F. Zephie Pasadena Md.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Arteriosclerotic Heart Disease to coronary insufficiency</u> (B) <u>Myocardial infarct</u> (C) <u>chronic</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 65 to Sept. 1967, that (I) (we) last saw the deceased alive on Sept. 5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Lyall		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/15/67	
23C. PHYSICIAN'S NAME (Type) RICHARD LYALL		23D. ADDRESS M.D. 1228 S. Ches. St. Balto. Md 21220			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9/18/67	24C. NAME OF CEMETERY OR CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Glen Burnie Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Rene E. Taylor		25C. FUNERAL DIRECTOR McLally 130 E. Fort Ave.	

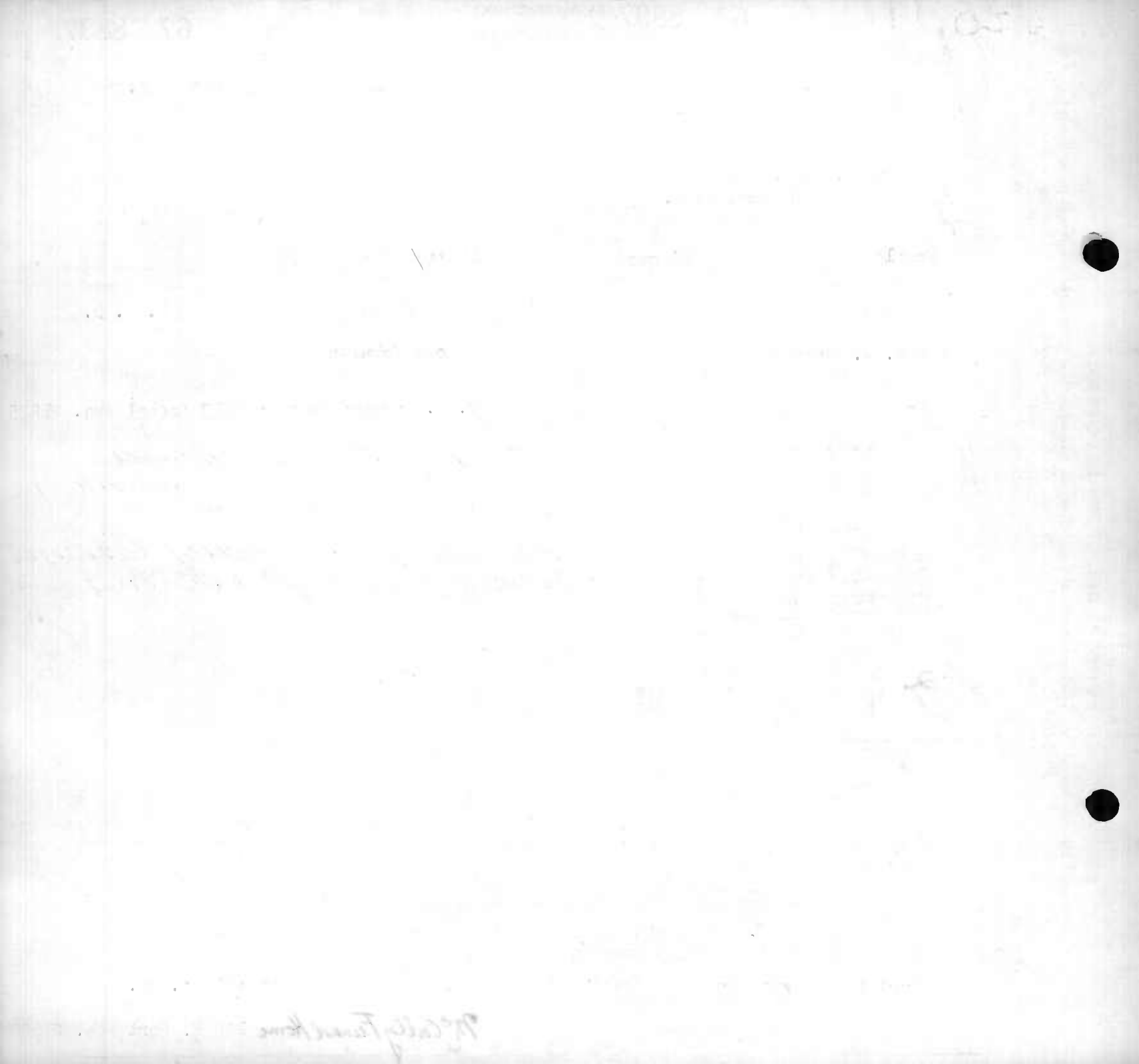
Dr. J. H. Smith
Moore City, N.C.
Sept 10, 1914

Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 8th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

FUNERAL DIRECTOR: IMPORTANT

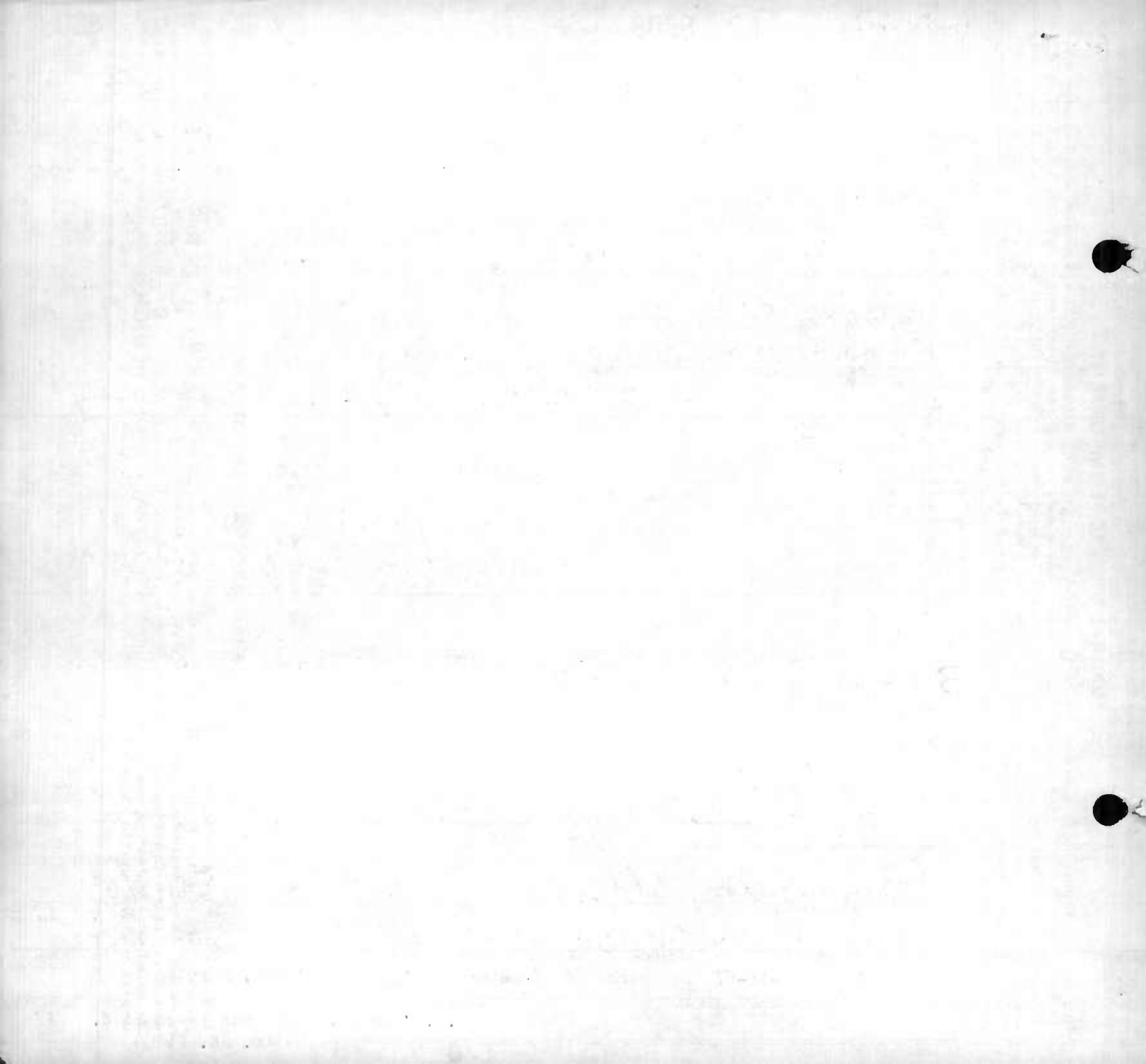
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8897		CERTIFICATE OF DEATH		67 8897	
1. NAME OF DECEASED (Type or Print) MORRIS, LILLIE M			2. DATE AND HOUR OF DEATH September 15, 1967 1:35 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Agnes Hospital Caton & Wilkens Aves. 40 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) Summit Nursing Home (Catonsville, 28)		
5. SEX Female	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11/27/1888	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Geo. W. Schuman			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME Rose Schultz			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mr. W. Raymond Schuman 513 Anabel Ave. 21225		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic carcinoma (carcinoma) to the liver.			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Possibly primary carcinoma of the pancreas.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rafael Marin M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 9/15/67	
23C. PHYSICIAN'S NAME (Type) Rafael Marin				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR McCally Funeral Home 130 E. Fort Ave. 21230			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8899		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8899	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) JAMES SAUTER			9-12-67 12:30 AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY		
5. SEX MALE			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
6. RACE NEGRO			D. STREET ADDRESS (If rural, give location) 1518 NORTH CAROLINE STREET		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE			E. AGE (In years last birthday) 34		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) Balto., Md.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME HERMAN SAULTER			14. MOTHER'S MAIDEN NAME MARY KELLY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			17. INFORMANT ADDRESS Herman Sauter 1507 N. Caroline St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of organ, e.g., heart failure, asthenia, etc. It means the cause, injury or complication which caused death.) PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No) YES		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9-9-67 to 9-12-67 , that (I) (we) last saw the deceased alive on 9-12-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Major W. Bradshaw			23B. DATE SIGNED 9-12		
23C. PHYSICIAN'S NAME (Type) MAJOR W. BRADSHAW			23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9/15/67		
24C. NAME OF CEMETERY or CREMATORY St. Calvary Cemetery			24D. LOCATION (City, town or county) (State) Calver Hill, Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967			25B. NAME OF REGISTRAR Robert E. Fink		
25C. FUNERAL DIRECTOR Williams Funeral Home			25D. ADDRESS 319 N. Broadway		

100-100000

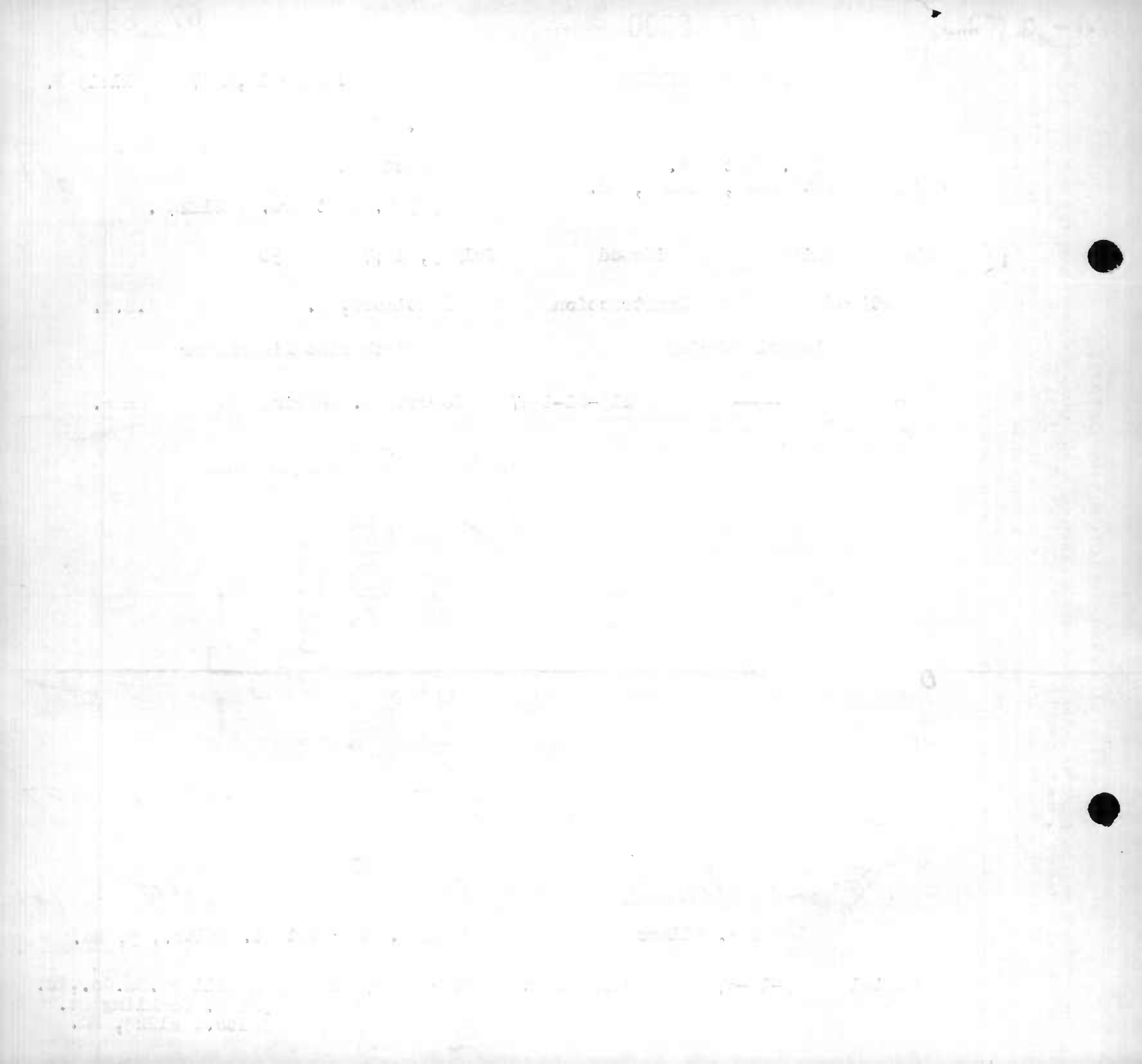
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

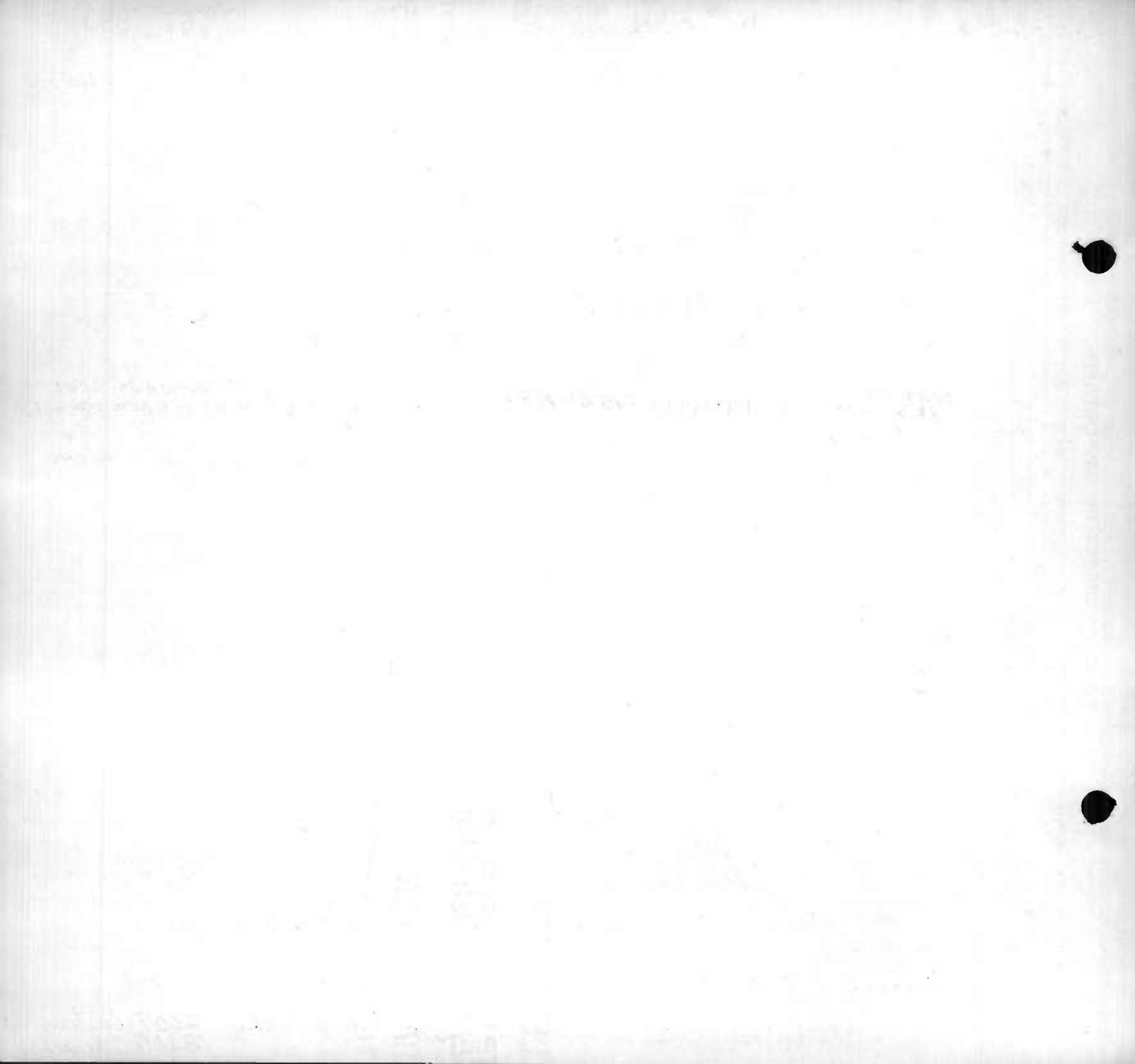
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8900	
BIRTH NO. 67 8900		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MICHAEL MEHRING		2. DATE AND HOUR OF DEATH September 14, 1967 11:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 505 S. East Ave. Baltimore, 21224, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 505 S. East Ave. # 21224.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 9, 1877	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Mehring		14. MOTHER'S MAIDEN NAME Catherine Eisenhower	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-1427		17. INFORMANT Loretta M. Mehring	
18. 444 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) arteriosclerotic heart disease DUE TO (B) Hypertension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ? ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1 19 67 to Sept 14 19 67 . that (I) (we) last saw the deceased alive on Sept 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Louis F. Klimes		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept. 15, 1967	
23C. PHYSICIAN'S NAME (Type) Louis F. Klimes		23D. ADDRESS M.D. 2623 E. Monument St. Balto., 5, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-18-67		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd. Ba. Co., Md.		25A. DATE RECEIVED SEP 18 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Charles J. Guder		25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8901					Registered No. 67 8901				
CERTIFICATE OF DEATH									
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH	
					Arthur John Witts			Sept. 15, 1967 12:35 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
91 Montebello State Hospital					Maryland				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					418 S. Dallas St.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED (Specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
M	W			10-28-97	69	Maryland		USA.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY							
City Employee		CITY OF BALTO.							
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Emmanuel Witts					Anna Smith				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
YES W.W.I. - 1919-1921					215 094199		Hospital Chart ANNA M. LOWERY P.O. BOX 53A-RT-1 - BALTO. MD. 21221		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
153.8 I					Adenocarcinoma of colon one year				
ANTECEDENT CAUSES					INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Sept. 11 1967 to Sept. 15 1967, that (I) (we) last saw the deceased alive on Sept. 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Cesar J. Pellerano M.D.					Sept. 15, 1967				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Cesar J. Pellerano M.D.					Montebello State Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		9-18-67		St. Stanislaus Cem.		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR		ADDRESS		
SEP 18 1967		R. B. E. Jenkins			Wm. Fialkowski		2007 Eastern Ave Bald. Md. 21231		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8902	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 8902</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>Melvin Brown Sr.</i></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <i>9-14-67 10⁰⁰ A.M.</i></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 MERCY HOSP.</i></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <i>Maryland</i> B. COUNTY <i>Balto. Co.</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 53-00</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>3656 Paskins Place</i></p>		
5. SEX <i>MALE</i>	6. RACE <i>CAUCASIAN</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>11-4-1916</i>	9. AGE (In years last birthday) <i>50</i>	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Policeman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. Md. City</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>United States</i>
13. FATHER'S NAME <i>William Brown</i>			14. MOTHER'S MAIDEN NAME <i>Marie Staroneck</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1943-1945</i>		16. SOCIAL SECURITY NO. <i>215-14-8996</i>	17. INFORMANT <i>Randallstown, Md.</i> <i>Mrs. June C. Brown 3656 Paskins Place</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Acute Myocardial Infarction day</i> DUE TO (B) <i>Atherosclerotic Heart Disease</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>9-13 1967</i> to <i>9-14 1967</i>, that (I) (we) last saw the deceased alive on <i>9-13 1967</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE <i>J. M. Thorne</i>				23B. DATE SIGNED <i>9-14-67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sept. 18, 1967</i>		24C. NAME of CEMETERY or CREMATORY <i>Balto. National Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 18 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Tabor</i>		25C. FUNERAL DIRECTOR <i>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</i>			

Page 11 of 11

Cambridge, MA
June 1, 1964

1964-1965

1964-1965

1964-1965

1964-1965

1964-1965

1964-1965

1964-1965

1964-1965

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H-514

67 8903 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8903

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)F.
CHARLES HONFELDT

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1967 7:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)00
2738 Harford Road4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2738 Harford Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

June 16, 1891

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

B & O Railroad

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Homfeldt

14. MOTHER'S MAIDEN NAME

Regina Schaefferman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

4-16-18 8-14-19

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Herman Homfeldt 3122 Chesterfield Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

September 15, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-19-1967

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

NEW FINGER

Jan 10, 1902

Jan 10, 1902

Jan 10, 1902

Jan 10, 1902

Jan 10, 1902

Jan 10, 1902

Jan 10, 1902

Jan 10, 1902

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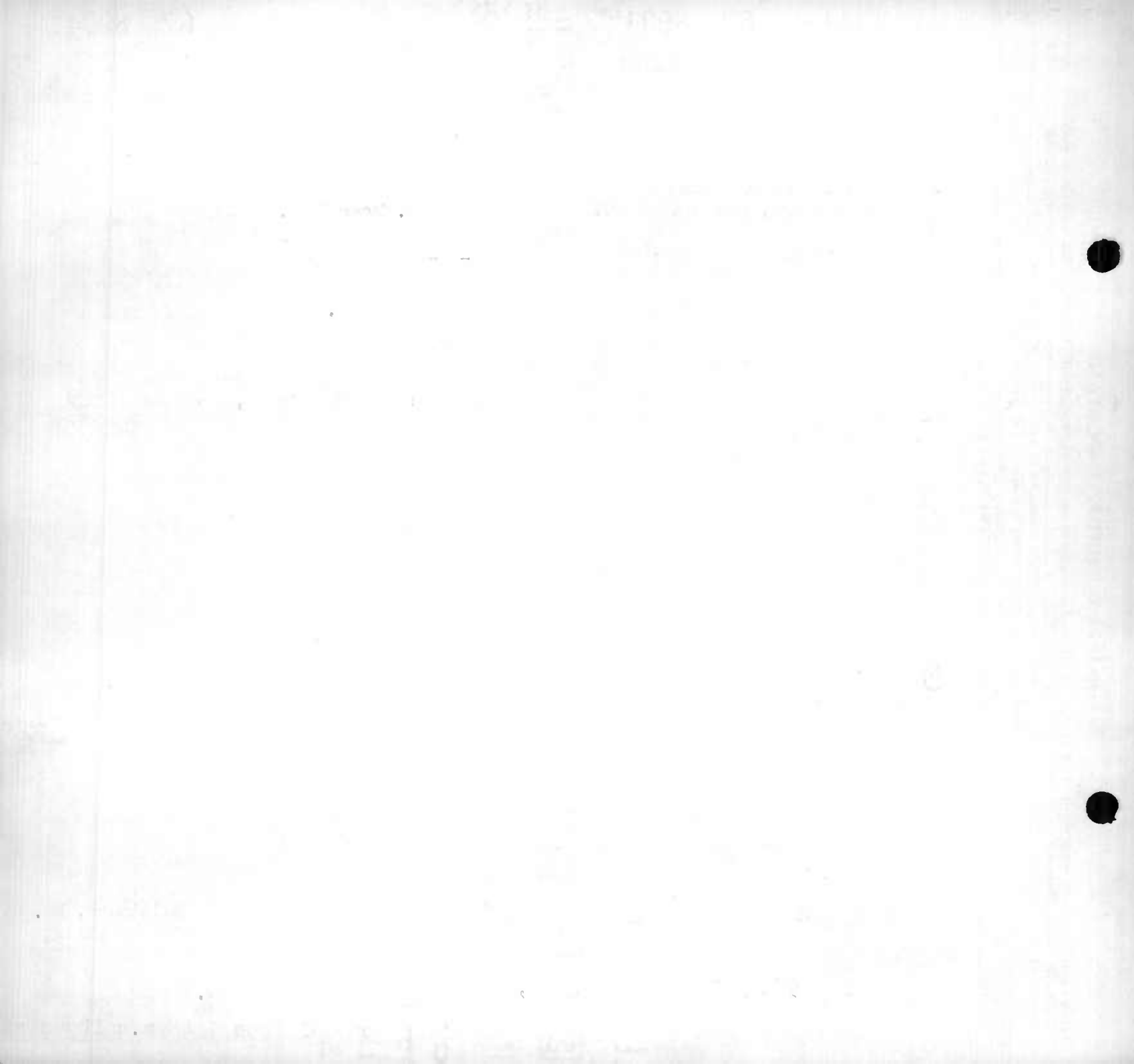
Jan 10, 1902

Jan 10, 1902

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 0416 67 8904				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8904	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) OLIVER, SANDY				2. DATE AND HOUR OF DEATH 9/15/67 12:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2841 E. Federal St. #21213			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-15-08	9. AGE (In years last birthday) 59	10. CITIZEN OF WHAT COUNTRY? Va.		11. BIRTHPLACE (State or foreign country) Va.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Oliver				14. MOTHER'S MAIDEN NAME Lillie Pather			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PROB. ASPIRATION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CA of LARYNX + NECK.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA of Larynx		20A. AUTOPSY? (Yes or No) NO NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 7/19/67 to 9/15/67 and that (1) (we) lost the deceased alive on 9/15/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stuart Beal Silver				23B. DATE SIGNED 9/15/67		23C. PHYSICIAN'S NAME (Type) STUART BEAL SILVER M.D.	
23D. ADDRESS Balt. City Hospitals #21224		24. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 9/20/67		24C. NAME OF CEMETERY or CREMATORY Crew, Va		24D. LOCATION Crew Va.		24E. DATE REC'D BY HEALTH DEPT.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Kelson Funeral Home		25D. ADDRESS 1348 n. calhoun st	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8905	
BIRTH NO. 67 8905		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Michael Cuber Gentry		2. DATE AND HOUR OF DEATH 9/14/67 11:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 548 Wilson St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 548 Wilson St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/12/83	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Gentry			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Bessie Gentry 548 Wilson St.	
18. H42 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/13/67 to 9/14/67 that (I) (we) last saw the deceased alive on 9/14/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Borofsky		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/15/67	
23C. PHYSICIAN'S NAME (Type) S. Borofsky		23D. ADDRESS 601 N. Howard St. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.	
		24D. LOCATION Arbutus, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Fagan		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1548 N. E. 16th St.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. T-610		67 8906		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8906	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Jeremiah Tripp				2. DATE AND HOUR OF DEATH 9-16-67 9:36 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 1920 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MD B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1133 N. Calhoun St 21217			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10-17-93	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JACOB Tripp				14. MOTHER'S MAIDEN NAME FRANCES Clea			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 18-8-5775		17. INFORMANT ADDRESS BCH: RECORDS 4940 EASTERN AVENUE 21224	
18. 420.1 + 002.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cardiac Arrest DUE TO (B) Myocardial Infarct DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 15 min 48 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pneumonia, TB?			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9-14 19 67 to 9-16 19 67 , that (1) (we) lost saw the deceased alive on 9-16 19 67 and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert A. Cordes				23B. DATE SIGNED 9-16-67			
23C. PHYSICIAN'S NAME (Type) DR. ROBERT A. CORDES				23D. ADDRESS 4940 EASTERN AVENUE BALTO. MD. 21224 Baltimore City Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 9-20-67	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pl		24D. LOCATION (City, town, or county) (State) Arbutus, MD			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Rev. Nelson		ADDRESS 1348 N. Calhoun St	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8907		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8907	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROSA THREADGILL		2. DATE AND HOUR OF DEATH 9-17-67 8:35A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1303 W. LANVALE STREET			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 10-15-89	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME BAILEY, HENRY			14. MOTHER'S MAIDEN NAME ROBERTSON, BESSIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-14-5510		17. INFORMANT Martha Threadgill ADDRESS 1303 Lanvale St.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 9 days CORONARY INSUFFICIENCY ATHROSCLEROSIS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/17/67 to 9/17/67 that (I) (we) last saw the deceased alive on 8:45AM 9/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Allen B. Kaiser M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9/17/67	
23C. PHYSICIAN'S NAME (Type) Allen B. Kaiser		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-20-67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Arbutus, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR Kelson Funeral Home ADDRESS 1348 Calhoun St.	



Y. H. 1932

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U. S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

2015

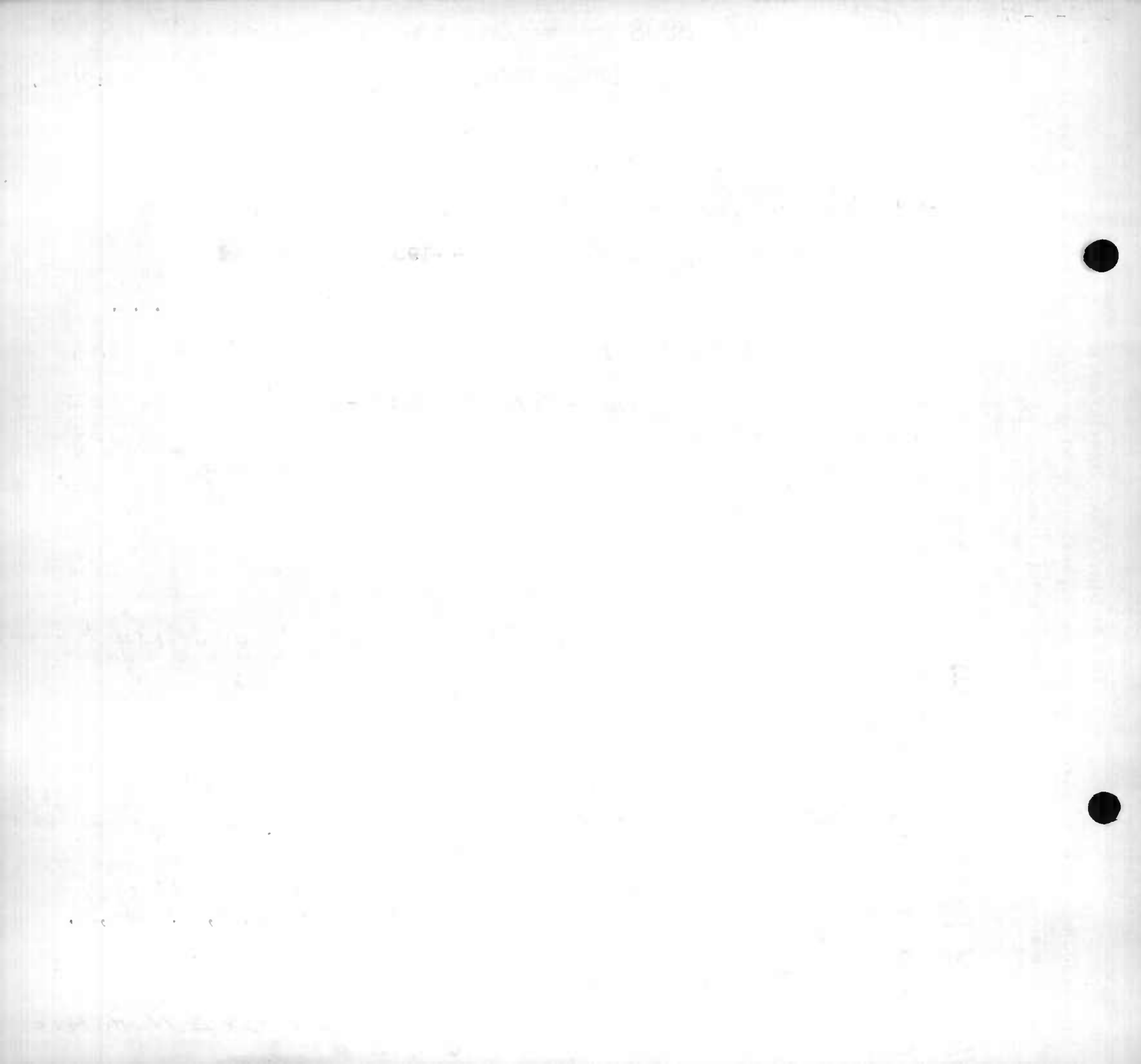
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WASHINGTON, D. C.

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U. S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8908		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8908	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN A. YOUNG (JOHN A YOUNG)		2. DATE AND HOUR OF DEATH 9/15/67 8:37 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9-08			
		D. STREET ADDRESS (If rural, give location) 1905 Oakhill Avenue 21218			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-1-1908	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Simpson Young		14. MOTHER'S MAIDEN NAME Janie (Roseboro)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-12-3642		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 163 X 1-002.2		CAUSE OF DEATH (A) DUE TO Spontaneous cell carcinoma lung (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH uncertain	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		old healed tuberculosis RUL ERUL reaction 15 yrs			
19A. DATE OF OPERATION 9/9 + 9/13/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Amputation		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8/18/67 19 67 to 9/15 19 67 , that (1) (we) last saw the deceased alive on 9/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leonard Lippman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/15/67	
23C. PHYSICIAN'S NAME (Type) LEONARD LIPPMAN		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. BALT. CITY HOSPITALS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-18-67		24C. NAME OF CEMETERY or CREMATORY Arbutes Mem. Park	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS WM. C. MARCH 928 E. North Ave	



1
J-232

67 8909

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 8909

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print) WILBUR

L.

JIGGETTS

2. DATE AND HOUR PRONOUNCED DEAD

September 15, 1967

4:26 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1116 W. Mosher St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
1116 W. Mosher St.

16-01

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

12-18-1904

9. AGE (In years last birthday)

61 62

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

DOPT STORE

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James K. Jiggetts

14. MOTHER'S MAIDEN NAME

Emma G. Yerby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

216-07-8406

17. INFORMANT

Emma G. Jiggetts 3231 YOSEMITE AVE

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease
(A) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Abscess of Lung

19A. DATE OF OPERATION

21

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/20/67

23C. NAME of CEMETERY or CREMATORY

Not known

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 18 1967

Robert E. Fairbank

Marlene P. Rogers 638 N. 9th St

12-12-1904
Baltimore MD
James K. Hight
2001 1000 1000 1000

James K. Hight
Baltimore MD
12-12-1904

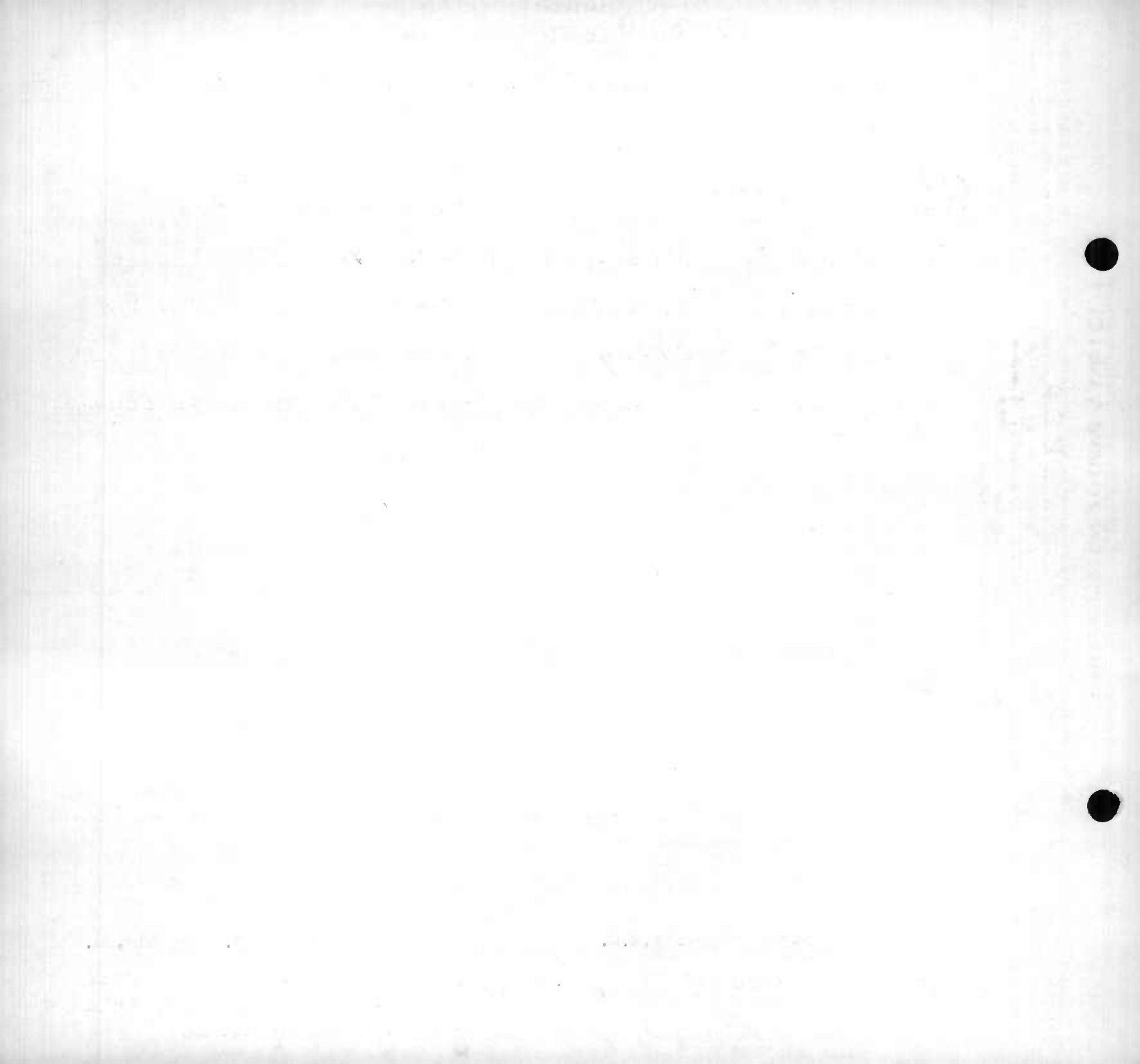
James K. Hight
Baltimore MD

James K. Hight
Baltimore MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8910</u>
BIRTH NO. <u>67 8910</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JEANETTE BARBARA LOWENSTEIN</u>		
2. DATE AND HOUR OF DEATH <u>SEPT. 17, 1967 8:05 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>003010 Highman AVE</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>25-52</u> D. STREET ADDRESS (If rural, give location) <u>3010 Highman AVE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB. 25, 1894</u>	9. AGE (In years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Freitag</u>		14. MOTHER'S MAIDEN NAME <u>MARGARETTA. LAUTERBECK.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-10-8090</u>		17. INFORMANT ADDRESS <u>MARGARET BENGES 1607 S. ELLAMONT ST.</u>
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>C.V.A.</u>		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Hypertension</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>Sept 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 17, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Stanley Ankudas, M.D.</u>		23B. DATE SIGNED <u>9.18.67</u>		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>319 Old Annapolis Rd. Ferndale, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9-20-67</u>		24C. NAME of CEMETERY or CREMATORY <u>LONDON PARK</u>
24D. LOCATION (City, town, or county) <u>BALTIMORE, Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 18 1967</u>		25B. NAME OF REGISTRAR <u>Geo. L. Schwab</u>		25C. FUNERAL DIRECTOR <u>Francis H. Miller</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8911				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8911	
1. NAME OF DECEASED (Type or Print) ELSIE E. Redekius				2. DATE AND HOUR OF DEATH Sept-17, 1967 4:19 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2119 Ramsey St			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-11-07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM Sheekells				14. MOTHER'S MAIDEN NAME HELEN KAUFMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT BEATHA GAUTH			ADDRESS 2119 RAMSAY ST.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.141260X (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION				CAUSE OF DEATH 4 hrs.		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES MELLITUS				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. YES.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/17 19 67 to 9/17 19 67 , that (I) (we) lost saw the deceased alive on 9/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas H. Emory				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/17/67	
23C. PHYSICIAN'S NAME (Type) THOMAS H. EMORY		23D. ADDRESS 586A.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-21-67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial		24D. LOCATION (City, town, or county) (State) Howard City Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR Geo. L. Schwab 1711 N. Charles St. Baltimore			

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2nd Baltimore General Hospital
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67 8912 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8912

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LUCY E. PAGE (TALBOT)				2. DATE AND HOUR PRONOUNCED DEAD September 13, 1967 ? M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2501 Salem Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2501 Salem Ave.			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1-18-32	9. AGE (In years last birthday) 35	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.	
13. FATHER'S NAME HAMMIE PAGE				14. MOTHER'S MAIDEN NAME CORA MORRIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JAMES E. Page 3807 Clifton Ave	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular Disease DUE TO (B) Pneumonia DUE TO (C)			
				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 9/18/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED September 13, 1967							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 9/18/67		23C. NAME of CEMETERY or CREMATORY Mt. Calvary		23D. LOCATION (City, town, or county) (State) G. D. County, Md.	
24A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		24B. NAME OF REGISTRAR Robert E. Fisher		24C. FUNERAL DIRECTOR Joseph S. Lock, Jr.		ADDRESS 1304 N. Central Ave	

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VALLEY FORGE

CHURCH

No
HARVEY
FARM

MARKED 1-11-32

VA
CORN
MARKED

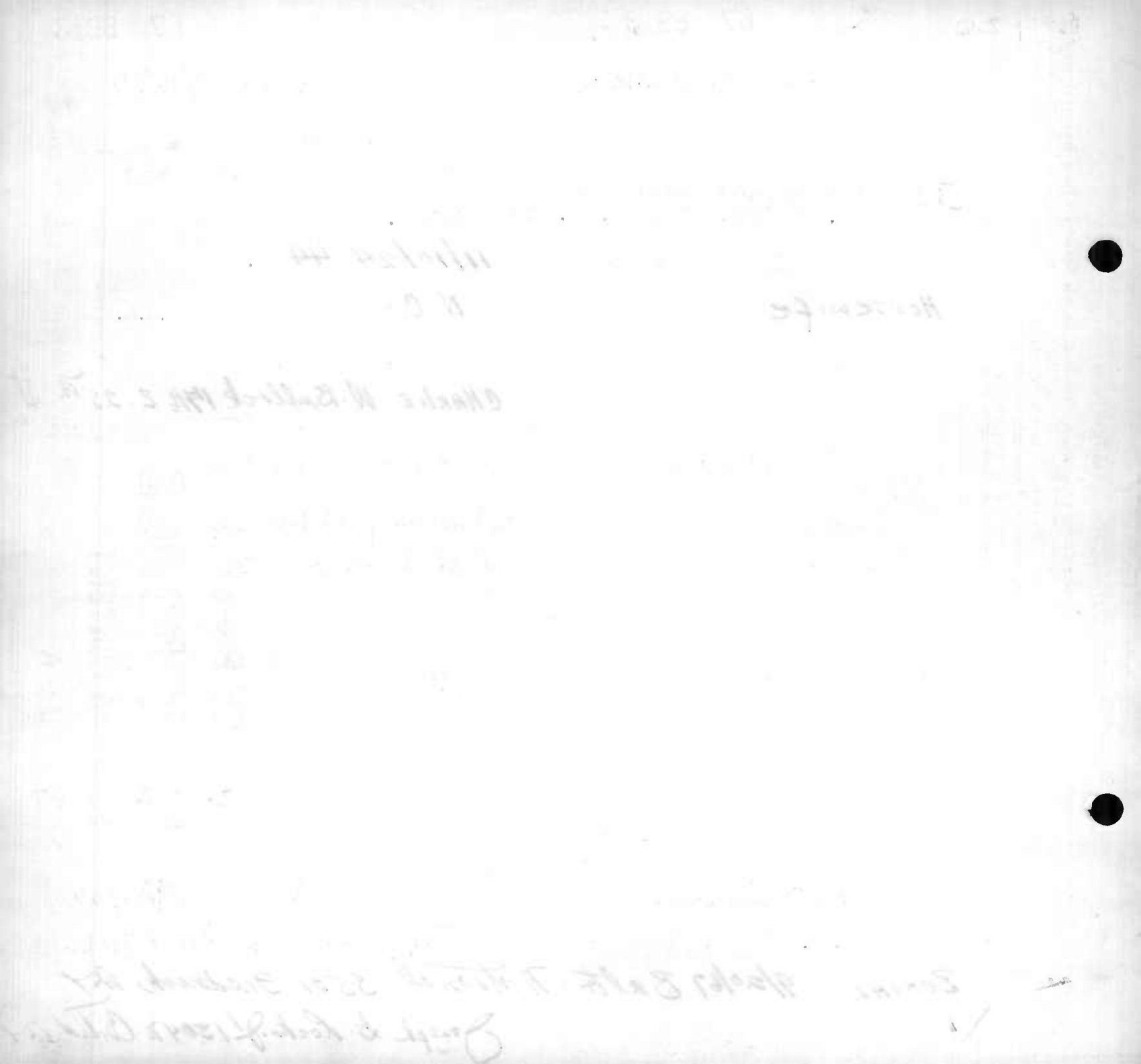
CHURCH

ENTER 2/10/32 BY CORNER A-D CORNER
JAMES A. B. & SON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 8913	
BIRTH NO. 67 8913		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ETNA M. Bullock			2. DATE AND HOUR OF DEATH 3:10 PM 9/16/67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital 601 N. Broadway, Baltimore, Md. 21205			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1716 E. 25th Street		
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/10/24	9. AGE (In years last birthday) 44	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SMITH, ED			14. MOTHER'S MAIDEN NAME WARWICK, HATTIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT CHARLIE W. Bullock ADDRESS 1716 E. 25th		
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Metastasis Ca of Cervix			INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT:					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to Sept 16 19 67 , that (I) (we) last saw the deceased alive on Sept 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K. E. Gilmour			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/16/67
23C. PHYSICIAN'S NAME (Type) K. E. GILMOUR,			23D. ADDRESS Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9/20/67	24C. NAME of CEMETERY, or CREMATORY Balto. National		24D. LOCATION (City, town, and county) (State) 5501 Frederick Ave	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph E. Rock ADDRESS 15047 Central Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-163 67 8914				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8914	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GRACE B. ROBERTS				2. DATE AND HOUR OF DEATH 9-16-67 9:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-04 D. STREET ADDRESS (If rural, give location) 611N. Chapel Gate La.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-10-1890		9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME FRANKLIN JOHNSON				14. MOTHER'S MAIDEN NAME —			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hazel R. Roberts Green Glade Rd. - Box 228C		
18. 451 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Ruptured aortic aneurysm DUE TO aortic aneurysm (B) H. A. S. C. V. D. DUE TO (C) 20 years		INTERVAL BETWEEN ONSET AND DEATH 20 years	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-16 19 67 to 9-16 19 67 . that (I) (we) lost saw the deceased alive on 9:00 PM 9-16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Byung Kap Kang						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) BYUNG KAP KANG				23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/20/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Witzke F. D/ - 4101 Edmondson Ave.		25C. FUNERAL DIRECTOR ADDRESS Witzke F. D/ - 4101 Edmondson Ave.			

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67 8915 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8915

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JAMES F. BELL 2. DATE AND HOUR PRONOUNCED DEAD September 16, 1967 7:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Baltimore Co

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

92 Baltimore City Jail

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

580 Frederick Road

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 8. DATE OF BIRTH 12/24/21 9. AGE (In years last birthday) 46 45 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Late William H. Bell 14. MOTHER'S MAIDEN NAME Virginia M. Denis nee Cain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Virginia Denis 580 Frederick Rd. ADDRESS

18. CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Tuberculosis, active

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21F. HOW DID INJURY OCCUR?

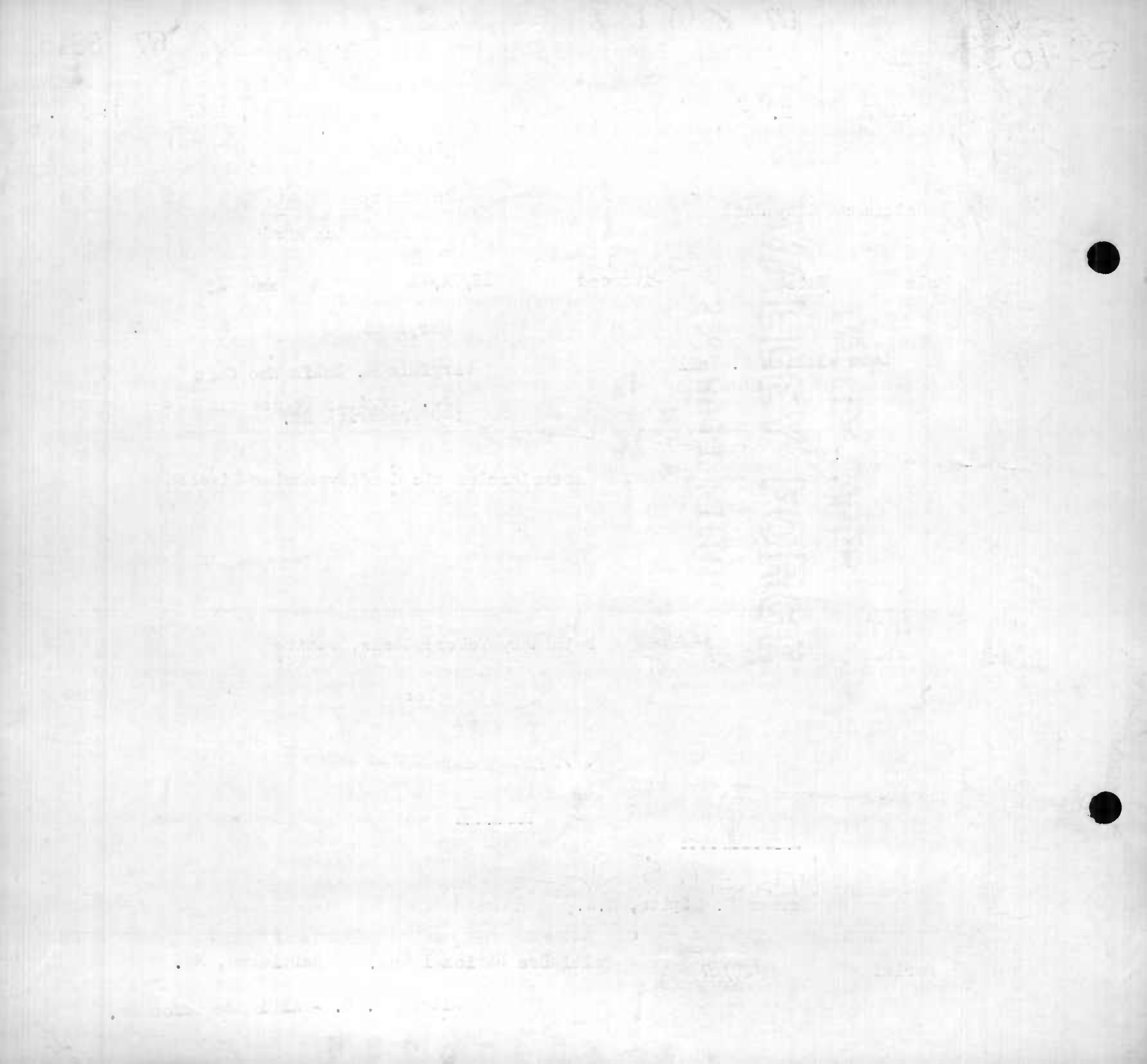
22. I certify that I held on Inquiry [] Inspection [] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []

ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER [] DATE SIGNED 9/16/67 ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER []

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 9/20/67 23C. NAME of CEMETERY or CREMATORY Baltimore National Cem. 23D. LOCATION (City, town, or county) (State) Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT. SEP 18 1967 24B. NAME OF REGISTRAR Robert E. Farkas 24C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Av. ADDRESS

VS 151-REV. 1/1/65 1 9 6 7 0 0 0 8 9 3 5



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8916				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8916	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JONES, IDA				2. DATE AND HOUR OF DEATH 9/16/67 11:18 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-18 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3343 W. BELVEDERE AVE.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/1/1904	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY MD		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME SOPIA HAMMOND			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-30-5470		17. INFORMANT FILMORE JONES - 504 BAKER ST. BALTO MD		ADDRESS	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PANCREATIC CARCINOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 9/16/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (the hospital) attended the deceased from 9/6/67 to 9/16/67 that (I) (we) last saw the deceased alive on 9/16/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ronald Schachar M.D.				23B. DATE SIGNED 9/16/67			
23C. PHYSICIAN'S NAME (Type) RONALD SCHACHAR M.D.				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/20/67		24C. NAME OF CEMETERY or CREMATORY Wt. Auburn		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR Wm. L. Schachar Jr. - 1701 M. E. Cullum St		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
67 8917				67 8917				67 8917			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Homer Gilmer Bowman				2. DATE AND HOUR OF DEATH Sept. 13, 1967				7:40 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION 2414 Madison Avenue				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				13-03			
				D. STREET ADDRESS (If rural, give location) 2414 Madison Ave.							
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 25, 1899	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Handler		10B. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Knoxville Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME White Bowman				14. MOTHER'S MAIDEN NAME Munsey Goins							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Nannie J. Bowman -2414 Madison Ave.				ADDRESS	
18. 16.3 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of lung DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 15 Months											
19A. DATE OF OPERATION 6-7-66				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of lung		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from May 9 19 66 to Sept 13 19 67 . that (I) (we) last saw the deceased alive on Sept 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE F. K. Adams				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept 15-67					
23C. PHYSICIAN'S NAME (Type) F. K. Adams				M.D. 1222 N. Caroline St		23D. ADDRESS					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/67		24C. NAME of CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Merrkirk Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS -3035 W. North Ave.					

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 8918		CERTIFICATE OF DEATH		67 8918	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
Green, William Lewis		9/17/67 8:48 A.M.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
Union Memorial Hospital		Baltimore 21206		530 Dale Ave	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	W	Married	3/3/10	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Repairman		Smelting & Refining Co. Md.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Robert Green		Emma		Unknown	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
218-12-0001		Mrs. Helen Green		(Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Renal Failure (B) Malignant Nephrosclerosis (C) Malignant Hypertension		4 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/17/67 to 9/17/1967, that (I) (we) last saw the deceased alive on 9/17/67 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
H. F. Holcomb				9/17/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
H. F. Holcomb		322 Stevenson Ave, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/19/67		Holy Rosary Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 18 1967		Robert E. Taylor		Leonard J. Ruck, Inc. Balto. Md. 21214	

W. F. H. 10/10/10
W. F. H. 10/10/10

325 Thompson Street
10/10/10
10/10/10

Malignant Hypertension
Malignant Hypertension

Renal Failure

Robert Green

W. F. H. 10/10/10
W. F. H. 10/10/10

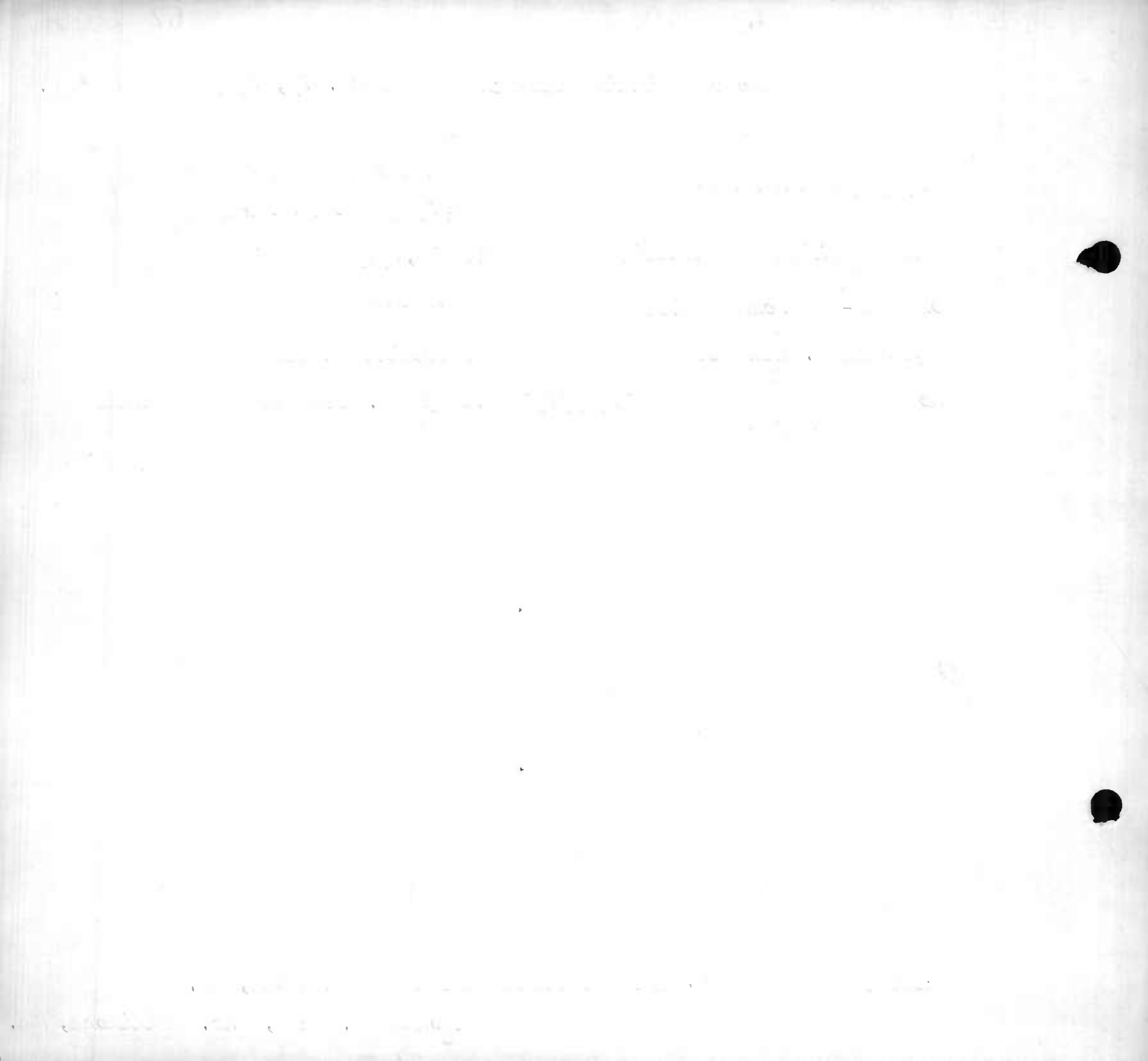
Robert Green

(cont)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

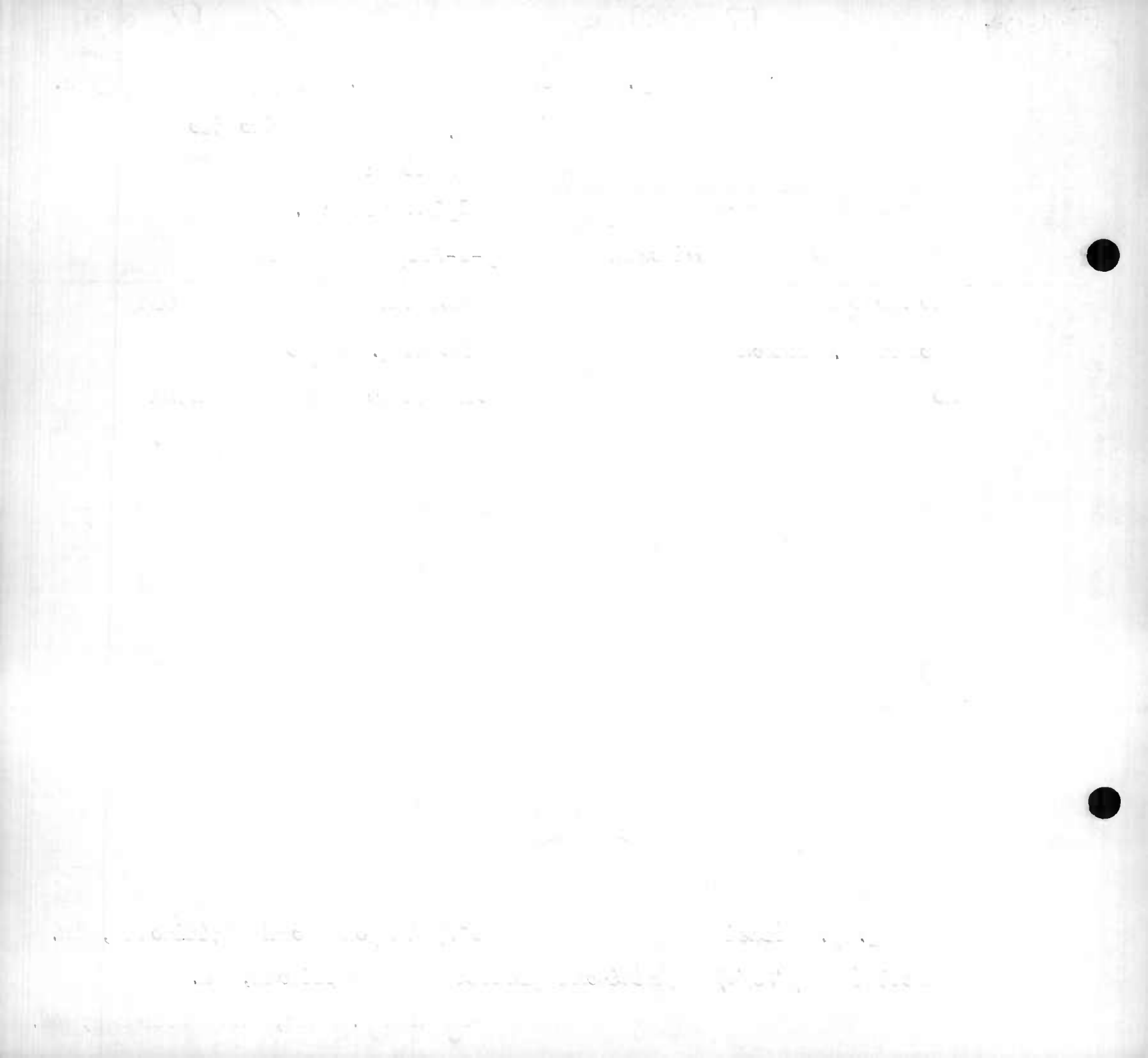
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8919	
BIRTH NO. 67 8919		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<i>Theodore William Lembach</i>		<i>Sept. 15, 1967</i> <i>1</i> <i>P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>6404 Eastern Parkway</i>		A. STATE <i>Maryland</i>			
		B. COUNTY <i>Baltimore</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give town)			
		<i>Baltimore 21214</i>			
		D. STREET ADDRESS (If rural, give location)			
		<i>6404 Eastern Parkway</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>July 21, 1905</i>	9. AGE (In years last birthday) <i>62</i>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Postman - U S Post Office</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Charles J. Lembach</i>			14. MOTHER'S MAIDEN NAME <i>Katherine Amreihn</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>214053132</i>		17. INFORMANT <i>Mrs Eva M. Lembach</i>
			ADDRESS <i>same</i>		
18. <i>163 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) <i>Coronoma lung</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>5/9/66 to 9/15/67</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>5/9/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Lung</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/10/66</i> to <i>9/15/67</i> and that (I) (we) last saw the deceased alive on <i>9/15/67</i> and that in (my) (our) opinion death occurred on the date <i>9/15/67</i> and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hugh J. Wreck</i>				23B. DATE SIGNED <i>Sept 16 67</i>	
23C. PHYSICIAN'S NAME (Type) <i>HUGH J. WRECK</i>				23D. ADDRESS <i>1205 N. Calvert Baltimore, Md.</i>	
24A. BURIAL CREMATION REMOVAL (Specify) <i>burial</i>		24B. DATE <i>9/18/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 18 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>	
				ADDRESS <i>Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8920				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8920	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Katherine G. Free</i>				2. DATE AND HOUR OF DEATH <i>Sept. 14, 1967 4:45 a. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<i>90 House in the Pines Nursing Home</i>		<i>5837 Belair Road</i>		<i>Md.</i>		<i>Wicomico Co.</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<i>Salisbury 72-12</i>			
				D. STREET ADDRESS (If rural, give location)			
				<i>232 Hazel Ave.</i>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
<i>female</i>	<i>white</i>	<i>widowed</i>	<i>5-6-1887</i>	<i>80</i>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>Housewife</i>			<i>Maryland</i>		<i>USA</i>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Joshua M. Hudson</i>				<i>Sarah E. Dagger</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
<i>no</i>					<i>Mrs Andrew Raab same</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<i>4-22-1 I</i>				<i>Arteriosclerotic Cardiovascular disease</i>		<i>1963</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO			
				<i>acute myocardial failure</i>		<i>2 days</i>	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 12 1963</i> to <i>Sept 14 1967</i> , that (I) (we) last saw the deceased alive on <i>Sept 14 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. J. Alessi</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. J. Alessi</i>				23D. ADDRESS M.D. <i>6217 Hartford Road Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>burial</i>		<i>9/18/67</i>		<i>Baltimore Cemetery</i>		<i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<i>SEP 18 1967</i>		<i>Robert E. Taberna</i>		<i>Leonard J. Ruck, Inc</i>		<i>Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

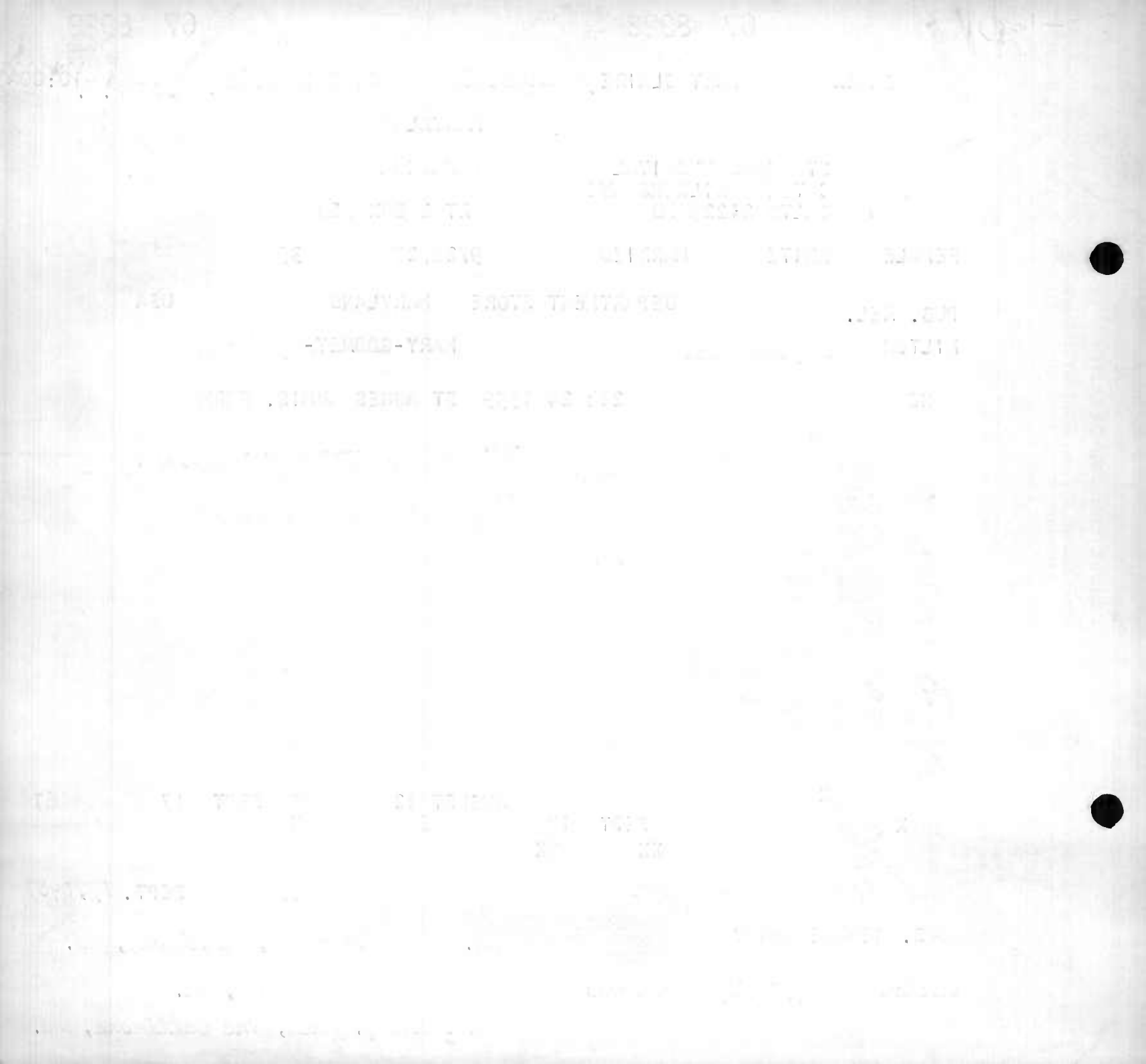
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-18688 67 8921				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8921 4	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Boy Bowser				2. DATE AND HOUR OF DEATH Sept. 15, 1967 10:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital, Inc. Baltimore, MD. 21202				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 21234 C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-05 D. STREET ADDRESS (If rural, give location) 3414 Chesley ave.			
5. SEX M	6. RACE W.	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Sept. 15, 1967		9. AGE (In years last birthday) 1 H-	If Under 1 Yr. Months: Days: Hours: Min. 0 0 1 10	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Mercy Hosp., Balto., MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arnold L. Bowser				14. MOTHER'S MAIDEN NAME Evelyn Pfeifer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father		ADDRESS 3414 Chesley ave. Balto. MD	
18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Immaturity - neonatal respiratory difficulty				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept. 15 19 67 to Sept. 15 19 67 , that (I) (we) last saw the deceased alive on Sept. 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sanj Kyun Shin				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 15, 1967	
23C. PHYSICIAN'S NAME (Type) Dr. G. Zarbin				23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/67		24C. NAME OF CEMETERY or CREMATORY Davis Cemetery		24D. LOCATION (City, town, or county) (State) Jefferson County, Pa.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Fickens		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8922 CERTIFICATE OF DEATH					Registered No. 67 8922				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) BAKER (MARY CLAIRE) Maryclaire					2. DATE AND HOUR OF DEATH SEPT 17 1967 11:00 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON & WILKENS AVE BALTO 2#229 MD					A. STATE MARYLAND				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA				
					D. STREET ADDRESS (If rural, give location) RT 2 BOX 92D				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED		8. DATE OF BIRTH 9/20/27	9. AGE (In years last birthday) 39	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PUB. REL.			10B. KIND OF BUSINESS OR INDUSTRY DEPARTMENT STORE			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MILTON Ross Gosweiler					14. MOTHER'S MAIDEN NAME MARY-ADONEX- Grieves				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214 24 1959		17. INFORMANT ADDRESS ST AGNES ADMIS. FORM				
1B. 683X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatic insufficiency Hepatic coma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
					(A) DUE TO				
					(B) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 12 19 67 to SEPT 17 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on SEPT 17 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.									
23A. SIGNATURE <i>S. George Angov</i>							23B. DATE SIGNED SEPT. 17, 1967		
23C. PHYSICIAN'S NAME (Type) S. GEORGE ANGOV							23D. ADDRESS St. Agnes Hospital, Baltimore, Md.		
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 9/20/67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967			25B. NAME OF REGISTRAR <i>Robert E. ...</i>			25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc Baltimore, Md.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8923

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACK

GAY

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1967

10:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

772 Washington Blvd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

12-13-1919

9. AGE (In years
last birthday)

47 28

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Merchant Seaman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry J. Gay

14. MOTHER'S MAIDEN NAME

Isabelle Boltwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs James Morningstar-4402 Alan Drive

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Metamorphosis of Liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

9-18-67

23C. NAME of CEMETERY or CREMATORY

Riverview Cemetery

23D. LOCATION

(City, town, or county)

(State)

Charlottesville, Virginia

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 18 1967

Robert E. Farley, M.D.

Leonard J. Ruck, Inc Baltimore, Md.

QUALITY PROFILE

VALUED REPORT

FOR THE CLIENT

1
F-630

67 8924 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8924

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) THOMAS G. FORTE		2. DATE AND HOUR PRONOUNCED DEAD September 16, 1967 5:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3435 Lyndale Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH March 5, 1951
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 16
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph A. Forte		14. MOTHER'S MAIDEN NAME Gertrude Klingenhofer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Joseph A. Forte
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E903.4 Spinal Cord Injury ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fracture of Fourth Cervical Vertebra.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Water	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Ocean City, Maryland	
21D. TIME OF INJURY (APPROX.) 9/4/67	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Sustained injury while surfing	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9/16/67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 9/19/67	23C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	23D. LOCATION (City, town, or county) (State) Balto. Md.
24A. DATE REC'D BY HEALTH DEPT. SEP 18 1967	24B. NAME OF REGISTRAR Robert E. Taylor	24C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.	

N 80412 67 8924

FUNERAL DIRECTOR: IMPORTANT

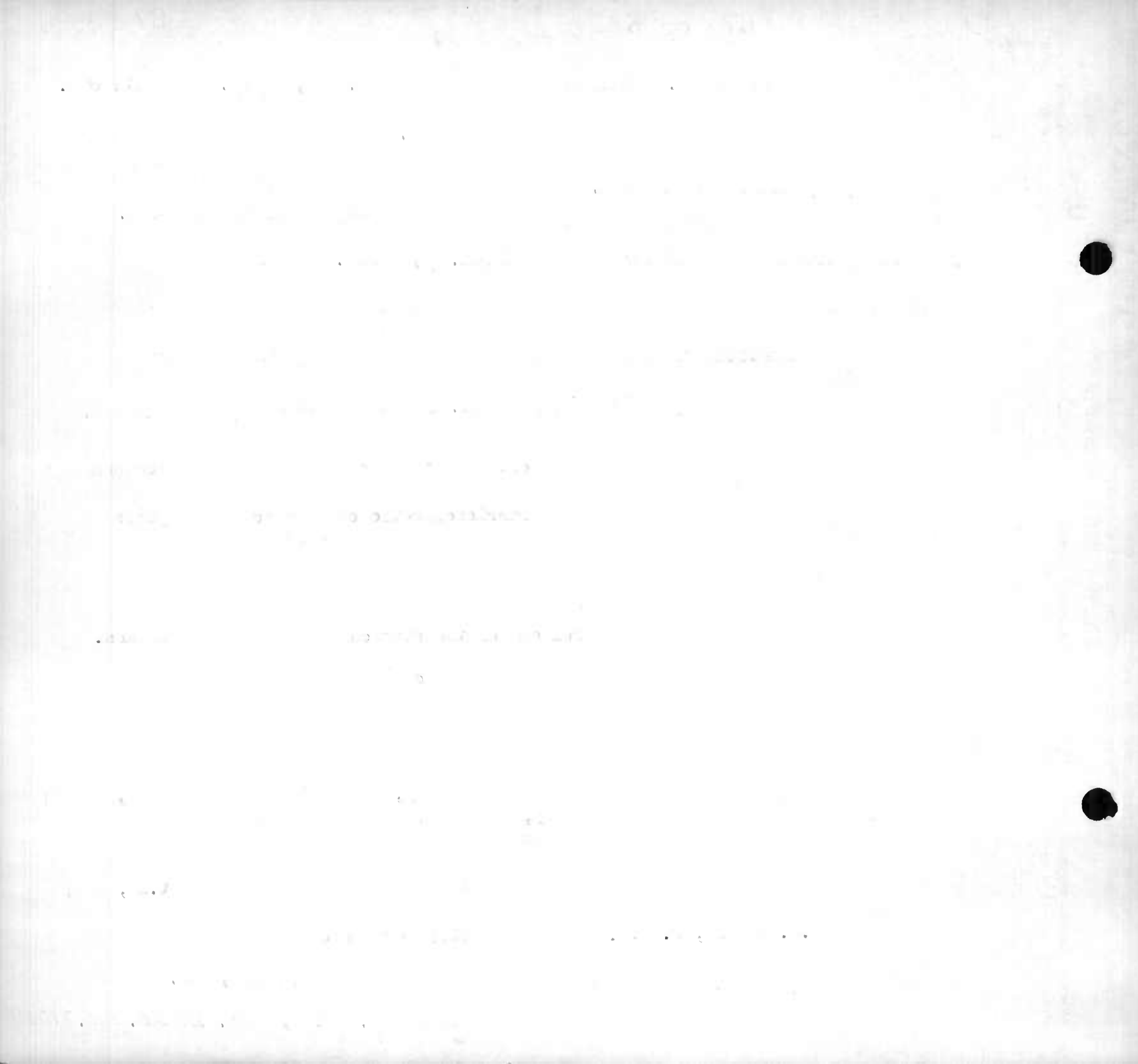
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8925	
BIRTH NO. 67 8925		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Aphrodite J. Constantinides		2. DATE AND HOUR OF DEATH 9/15/67 7⁴⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION House in the Pines Nursing Home 5837 Belair Road 9-22-67		A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3047 Northern Parkway			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Nov. 8, 1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Turkey	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nicholas Angeledes		14. MOTHER'S MAIDEN NAME Athena Youvakimides Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mr. Peter Constantinides (Same)	
18. 176.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Barotrauma of the Ventricle 18 mos.		18. 176.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Barotrauma of the Ventricle 18 mos.			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1954 to Sept 15 1967 , that (I) (we) last saw the deceased alive on Sept 15 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE E. J. Alessi		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/15/67	
23C. PHYSICIAN'S NAME (Type) E. J. Alessi		23D. ADDRESS 6217 Harford Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/67		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leonard J. Park			
25D. ADDRESS 5305 Harford Rd.					

FUNERAL DIRECTOR: IMPORTANT

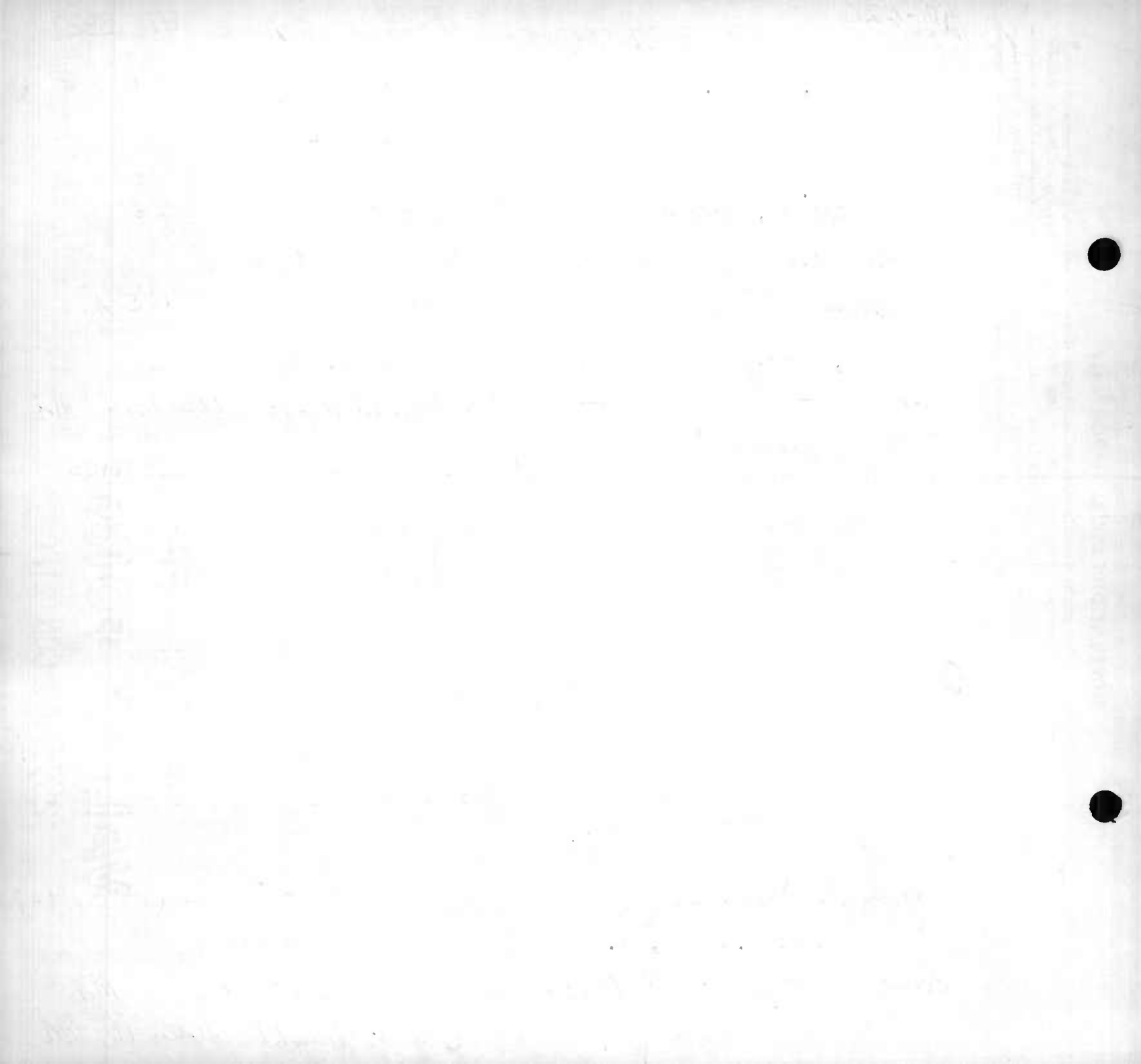
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 8926		67 8926	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Mildred R. Mareck			Sept. 16, 1967. 12:30 p. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Md.		
4809 Loch Raven Blvd.			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore 21212		
			D. STREET ADDRESS (If rural, give location)		
			4809 Loch Raven Blvd.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Female	White	Widow	Sept. 7, 1886	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Homemaker			Maryland		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Amos Reeder			Emma Bristow		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213102796		Mrs. Fannie Mason (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) Acute Coronary Occlusion		
ANTECEDENT CAUSES			DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerotic cardiovascular disease		
			DUE TO		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Carcinoma of the stomach		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		18 mos.
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (myself) attended the deceased from August 5, 19 62 to September 16, 19 67, that (I) (we) last saw the deceased alive on September 5, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
S.J. Venable, Jr. M.D.				Sept. 18, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
S.J. Venable, Jr. M.D.		7215 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		9/19/67		Cedar Hill Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 18 1967		Robert E. Taylor		Leonard J. Ruck, Inc. Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-620</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 8927</u>	
67 8927				CERTIFICATE OF DEATH			
M.E. CASE NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MYERS, FREDA M.</u>				2. DATE AND HOUR OF DEATH <u>Sept 13, 1967</u> <u>1</u> <u>6</u> <u>P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institutions: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u> <u>33 601 N. Broadway</u> <u>Baltimore, Maryland</u>				A. STATE <u>Maryland</u> , <u>Carroll Co</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Woodbine</u> D. STREET ADDRESS (If rural, give location) <u>Box 51</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>9/23/58</u>	9. AGE (In years last birthday) <u>8 yrs</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Myers, Howard</u>				14. MOTHER'S MAIDEN NAME <u>Anderson, Julia</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT ADDRESS <u>MR. HOWARD MYERS - Woodbine, Md.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>15510</u> <u>HEPATOBlastoma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>OCT 1965</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastasis to</u> <u>SP</u> <u>SP</u> <u>SP</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>Oct 65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hepato Blastoma</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3 July 1967</u> to <u>13 Sept 1967</u> , that (I) (we) lost saw the deceased alive on <u>Sept 13 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>James L. Hughes, Jr.</u>				23B. DATE SIGNED <u>Sept 13, 1967</u>		23C. PHYSICIAN'S NAME (Type) <u>James L. Hughes, Jr.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-16-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Michaels Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 18 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbanks</u>		25C. FUNERAL DIRECTOR <u>Henry W. Haight</u>		25D. ADDRESS <u>Lykensville, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 8928		CERTIFICATE OF DEATH		67 8928	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Carl A. Jagdhuber		2. DATE AND HOUR OF DEATH 9-14-67 12 30/pm M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland B. COUNTY Baltimore Co	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Baltimore - Dundalk 53-00		203 S. Woodwell Rd. 21222	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-16-12	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Turn Leader		10B. KIND OF BUSINESS OR INDUSTRY Armco Steel Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Karl Jagdhuber		14. MOTHER'S MAIDEN NAME Josephine Greiner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 716-05-8041		17. INFORMANT ADDRESS Records: BCH 4940 Eastern Avenue Baltimore, Maryland 21224	
18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cardiac arrest DUE TO (B) Vomiting, Aspiration DUE TO (C) possible MI		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-14-19 67 to 9-14-19 67, that (I) (we) last saw the deceased alive on 9-14-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mark L. Lowmiller M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-14-67			
23C. PHYSICIAN'S NAME (Type) Mark L. Lowmiller M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/67		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md.			

1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1		W-623 67 8929		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8929			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) PATTY WRIGHT			2. DATE AND HOUR PRONOUNCED DEAD September 12, 1967 9:35 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospital D.O.A.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Dundalk 53-00 D. STREET ADDRESS (If rural, give location) 2707 Page Drive		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH 2/4/17	9. AGE (in years last birthday) 50	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cloth Cutter		10B. KIND OF BUSINESS OR INDUSTRY London Fog		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Robert H. Wright			14. MOTHER'S MAIDEN NAME Martha Grubb		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 229-09-0614		17. INFORMANT (Wife) ADDRESS Mrs. Florence Wright, 2707 Page Dr. Dundalk, Md. 21222	
18. 422.1 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO Arteriosclerotic Cardiovascular Disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED September 13, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 9/18/67		23C. NAME of CEMETERY or CREMATORY Bethany Lutheran Church Cem.	
24A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.		24C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

O-570 67 8930		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8930	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Florena Owens</i>		Sept 14, 1967 4:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>2801 Raynon Ave</i> <i>Mid. Baptist Hosp</i>		D. STREET ADDRESS (If inst., give location) <i>1907 Division St</i>		14-03	
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Feb. 6, 1877</i>	9. AGE (In years, months, days) <i>90</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Charles H. Kerr</i>		14. MOTHER'S MAIDEN NAME <i>Mary J. Lord</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>T. Henderson Kerr</i> ADDRESS <i>1907 Division St</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <i>Coronary thrombosis</i> (B) DUE TO <i>Atherosclerosis</i> (C) <i>Senility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>Aug 1</i> 19 <i>65</i> to <i>Sept 13</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Sept 12</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>William G Polk</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>WILLIAM G POLK MD</i>		23D. ADDRESS <i>1141 W. Fulton St Baltimore</i>		23E. FUNERAL DIRECTOR <i>Thos. C. Hendley</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-16-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 18 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>	
25C. FUNERAL DIRECTOR <i>Thos. C. Hendley</i>		ADDRESS <i>578 W. Biddle St</i>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. K-152		67 8931		67 8931	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>William B Robinson</i>				Sept 13, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE <i>B. COUNTY</i> <i>822 N. Carrollton Ave Maryland</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				<i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location)				<i>16-01</i> <i>822 n. Carrollton.</i>	
5. SEX <i>4</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Oct 7-1883</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher.</i>			11. BIRTHPLACE (State or foreign country) <i>Balto City</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Charles A Berry</i>			14. MOTHER'S MAIDEN NAME <i>Mary Berry</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Zella Washington</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>420.01</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <i>Constrictive Heart Failure</i> (B) DUE TO <i>A.S.H.D.</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 yrs.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Seriously (89 yrs)</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug.</i> 19 <i>67</i> to <i>Sept. 7</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9/7</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>C. Dudley Lee Sr.</i>				23B. DATE SIGNED <i>9/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. Dudley Lee Sr.</i>				23D. ADDRESS <i>1501 - E Eager St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-16-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cem</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 18 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>(Mr) Francis A. Hemminger</i>	
ADDRESS <i>473 W. Biddle St.</i>					

Bellevue Hospital
New York City
May 1914

Dr. J. M. Smith
New York City

Smith (1914)

Dr. J. M. Smith
New York City
May 1914

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 8932 CERTIFICATE OF DEATH					Registered No. 67 8932				
BIRTH NO. <u>D-620</u>					1. NAME OF DECEASED (Type or Print) <u>Atlantis Hull Dorsey</u>				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH <u>Sept. 17, 1967</u> <u>10 15 p.m.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>638 E. 33rd St.</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, 21218</u>				
D. STREET ADDRESS (If rural, give location) <u>638 E. 33rd St.</u>					9-03				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>6/1/1886</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>A.K.V. Hull</u>			14. MOTHER'S MAIDEN NAME <u>Abbie V. Rice</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-46-2323</u>		17. INFORMANT <u>Lloyd Dorsey, Jr.</u>		ADDRESS <u>(Same)</u>		
18. CAUSE OF DEATH <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF PLEURA</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>NONE</u>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u>									
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NONE</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>January 1967</u> to <u>Sept 17 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 14 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. Pronounced by <u>Dr. G. O. S. S. M. M.</u>									
23A. SIGNATURE <u>A. S. Chalfant</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Sept 18, 1967</u>		
23C. PHYSICIAN'S NAME (Type) <u>A. S. Chalfant</u>					23D. ADDRESS M.D. <u>6210 York Road</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/20/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 18 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

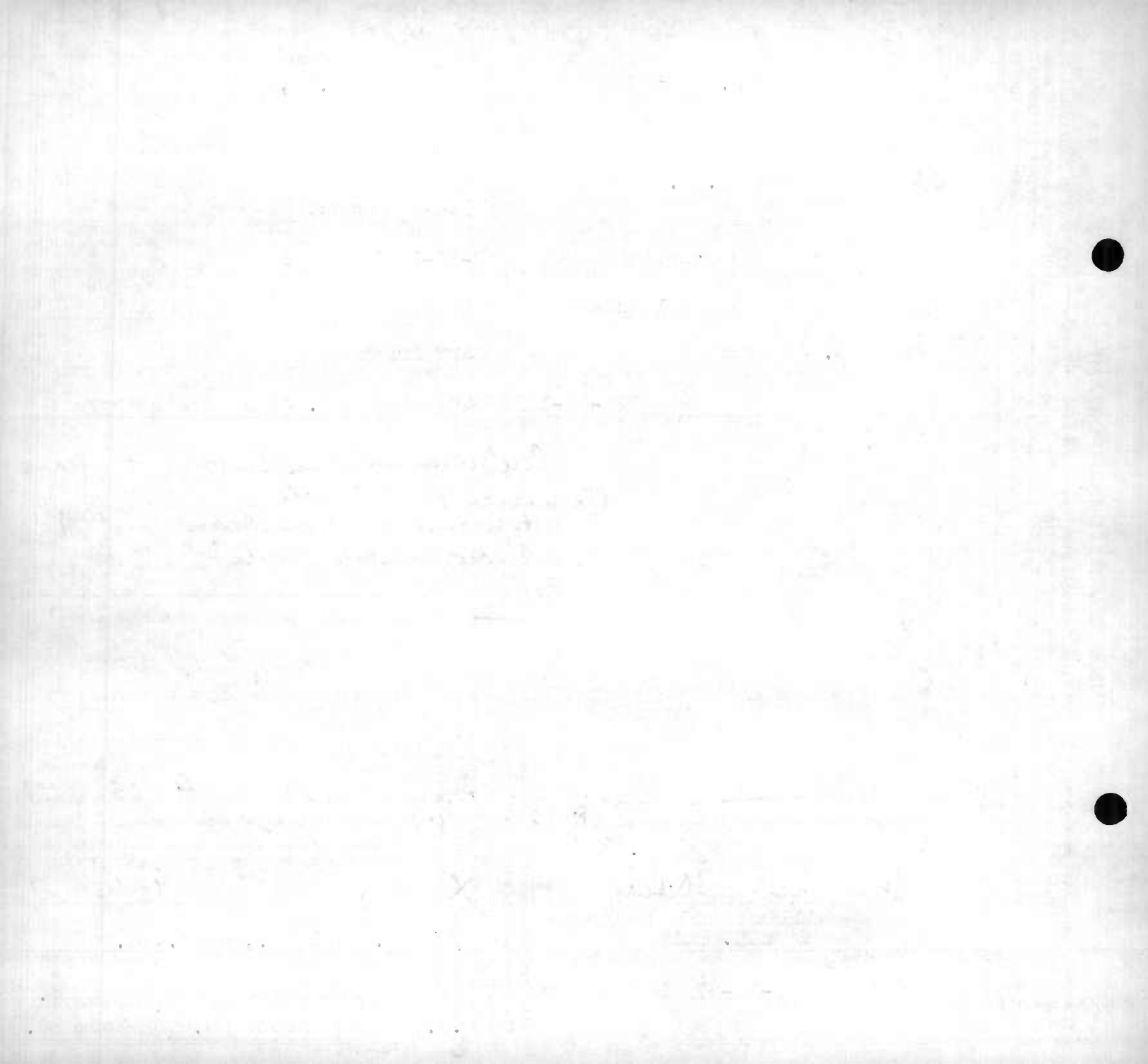
BIRTH NO. 67 8933				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8933	
1. NAME OF DECEASED (Type or Print) May G. Stump				2. DATE AND HOUR OF DEATH Sept. 16, 1967 12:45 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 218 Ridgewood Road Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) 100 W. University Pkwy.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 3/7/1888	9. AGE (In years last birthday) 79	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-State Board of Examiners				10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Alexander H. Stump				14. MOTHER'S MAIDEN NAME Nannie Woollen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-16-1184		17. INFORMANT Mrs. German H.H. Emory	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pneumonia DUE TO (A) Pneumonia (B) arteriosclerotic CVD (C) INTERVAL BETWEEN ONSET AND DEATH 5 days yes							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/25/54 19 to 9/16/67 19, that (I) (we) last saw the deceased alive on 9/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francis W. Gluck				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/18/67	
23C. PHYSICIAN'S NAME (Type) Francis W. Gluck				23D. ADDRESS M.D. 100 W. University Pkwy.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/67		24C. NAME of CEMETERY or CREMATORY St. Thomas		24D. LOCATION (City, town, or county) (State) Garrison Forest, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR R. E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-523 BIRTH NO.		67 8934		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8934	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JAY C. JOHNSON				2. DATE AND HOUR OF DEATH Sept. 15, 1967 6:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green N. H.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) 3601 Greenway			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-20-1881	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10B. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob C. Johnson				14. MOTHER'S MAIDEN NAME Mary Brannon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-1338		17. INFORMANT Charolette K. Johnson		ADDRESS Above	
18. 443 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Cerebrovascular accidents (Thromboses) multiple ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis Cerebrovascular Disease				CAUSE OF DEATH 4 years 10 yrs		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 19 57 to 9-15-19 67 , that (I) (we) last saw the deceased alive on 8-22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Wm Carl Ebeling				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-16-67	
23C. PHYSICIAN'S NAME (Type) William Carl Ebeling				23D. ADDRESS 701 St. Paul St., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-18-67		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR John A. G. Farley		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.			



1

L-520 67. 8935 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 8935

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WALTER R. LOMAS		2. DATE AND HOUR PRONOUNCED DEAD September 15, 1967 7:55 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals (DOA)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY Montgomery C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hatboro D. STREET ADDRESS (If rural, give location) 414 Corinthian Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 14, 1918
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) aeronautical Engineer		10B. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	9. AGE (In years last birthday) 49
13. FATHER'S NAME Walter M. Lomas		11. BIRTHPLACE (State or foreign country) Westhampton, New York	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		14. MOTHER'S MAIDEN NAME (unknown) McNally	12. CITIZEN OF WHAT COUNTRY? U.S.A.
16. SOCIAL SECURITY NO. unknown		17. INFORMANT ADDRESS Grace H. Lomas 414 Corinthian Ave. Hatboro Penna	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 9/15/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 7:19 P.	20A. AUTOPSY? (Yes or No) No
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21D. TIME OF INJURY (APPROX.) 9/15/67 7:19 P.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 620 ft. S. of Clover Avenue Middle River Road - Essex, Md.
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subj. Passenger in car - involved in head-on collision.	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL, etc. (Specify) Burial		23B. DATE 9/19/67	23C. NAME OF CEMETERY or CREMATORY Hatboro Cemetery
24A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	24C. FUNERAL DIRECTOR Loring Byers 8728 Liberty Road Randallstown, Md.
24D. LOCATION (City, town, or county) (State) Hatboro, Montgomery Co. Pa.		ADDRESS	

VS 151-REV. 1/1/65

Washington, D.C.

Mr. [Name]

Dear Sir:

I am writing to you regarding

the [Subject]

Sincerely,

Very truly yours,

[Signature]

[Title]

Enclosed for you are [Number] copies of [Document]

Very truly yours,
[Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-520 BIRTH NO.		67 8936 M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8936	
1. NAME OF DECEASED (Type or Print) Helen C. Funk				2. DATE AND HOUR OF DEATH 9-13-67 11:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 91 Keswick (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore (rural)			
				D. STREET ADDRESS (If rural, give location) 7125 Campfield Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 4-21-02	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Manager, Baltimore Trust		10B. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clyde C. Rohr				14. MOTHER'S MAIDEN NAME Nellie Snyder			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 222-09-8125		17. INFORMANT Paul H. Funk ADDRESS 3939 Roland Ave. Balto 11, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO Cerebro-Vascular Accident Recent & old		3 1/2 days & 5 hrs.	
				(B) DUE TO Pneumonia		2 1/2 days	
				(C) DUE TO Diabetes Mellitus		11 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 31 1965 to Sept 13 1967 , that (II) (we) lost saw the deceased alive on Sept 13 1967 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Aubrey D. Richardson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 14 Sept 1967	
23C. PHYSICIAN'S NAME (Type) Aubrey D. Richardson				23D. ADDRESS M.D. Keswick - 700 W. 40th Street, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/67		24C. NAME of CEMETERY or CREMATORY Balto National Cemetery		24D. LOCATION (City, town, or county) (State) 5501 Frederick Rd. Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Byers Loring		ADDRESS 8728 Liberty Road Randallstown, Md.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT	
W-520 BIRTH NO. 67-10565 67. 8937		CERTIFICATE OF DEATH. 67. 8937	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <i>June 2, 1967 6:30 pm</i>	
1. NAME OF DECEASED (Type or Print) <i>Baby Boy Weems</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>THE JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>LUTHERVILLE</i> D. STREET ADDRESS (If rural, give location) <i>1443 BELLONA AVENUE</i>	
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>5-28-67</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <i>--</i>
13. FATHER'S NAME <i>GEORGE E. WEEMS</i>		14. MOTHER'S MAIDEN NAME <i>DANNETTE JOHNSON</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. <i>723.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Repeated cardiopulmonary arrests with resultant metabolic acidosis</i> (B) <i>Prematurity</i> INTERVAL BETWEEN ONSET AND DEATH <i>7 1/2 hrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>birth 5/28 1967</i> to <i>6/2 1967</i> , that (1) (we) last saw the deceased alive on <i>6/2 1967</i> and that (my) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.			
23A. SIGNATURE <i>J. A. Eeliot</i>		23B. DATE SIGNED <i>6/2/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. A. EELIOTT</i>		23D. ADDRESS <i>Johns Hopkins Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i>		24B. DATE <i>62-67</i>	
24C. NAME of CEMETERY or CREMATORY <i>JOHNS HOPKINS HOSPITAL</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 19 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>HOSPITAL DISPOSAL</i>		ADDRESS	

Brig Gen Wm

June 2, 1867

Reported cardiology with
with constant with
a cardiac
B. Presumably

John Thomas
1
6/13/67
6/13/67
6/13/67
6/13/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-520 67 8938				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8938	
BIRTH NO.				M.E. CASE NO.		1. NAME OF DECEASED	
LILLIAN BANKS				LILLIAN BANKS		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE MARYLAND		B. COUNTY	
5. SEX Female				6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	
8. DATE OF BIRTH 12/25/06				9. AGE (In years last birthday) 60		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME VIRGINIA				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224				18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				20. CAUSE OF DEATH (A) Massive intracerebral thrombosis (B) From negative space (C)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Low fibrinogen & bleeding diathesis	
22. DATE OF OPERATION				23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No) YES	
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. TIME OF INJURY (Month) (Day) (Year) (Hour)				29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
31. I certify that (I) (this hospital) attended the deceased from 9/12 1967 to 9/13 1967, that (I) (we) last saw the deceased alive on 9/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				32. SIGNATURE Zachary D. Grossman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		33. DATE SIGNED 9/13/67	
34. PHYSICIAN'S NAME (Type) ZACHARY D. GROSSMAN				35. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224		36. DATE	
37. BURIAL, CREMATION, REMOVAL (Specify) Burial				38. DATE 9/16/67		39. NAME OF CEMETERY OR CREMATORY Mt Auburn	
40. DATE REC'D BY HEALTH DEPT. SEP 19 1967				41. NAME OF REGISTRAR Robert E. Taylor		42. FUNERAL DIRECTOR Charles A. Rice	
43. ADDRESS 6614 Barre				44. ADDRESS		45. ADDRESS	

J-520

67 8939 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8939

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL JONES

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1967 10:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 824 S. Hanover

D.O.A.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

724 E. 20th Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/5/22

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Samuel Jones

14. MOTHER'S MAIDEN NAME

Marie Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown); (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Carrie Jones 3001 Seabury Rd.

18.

331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Intracerebral hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/21/67

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

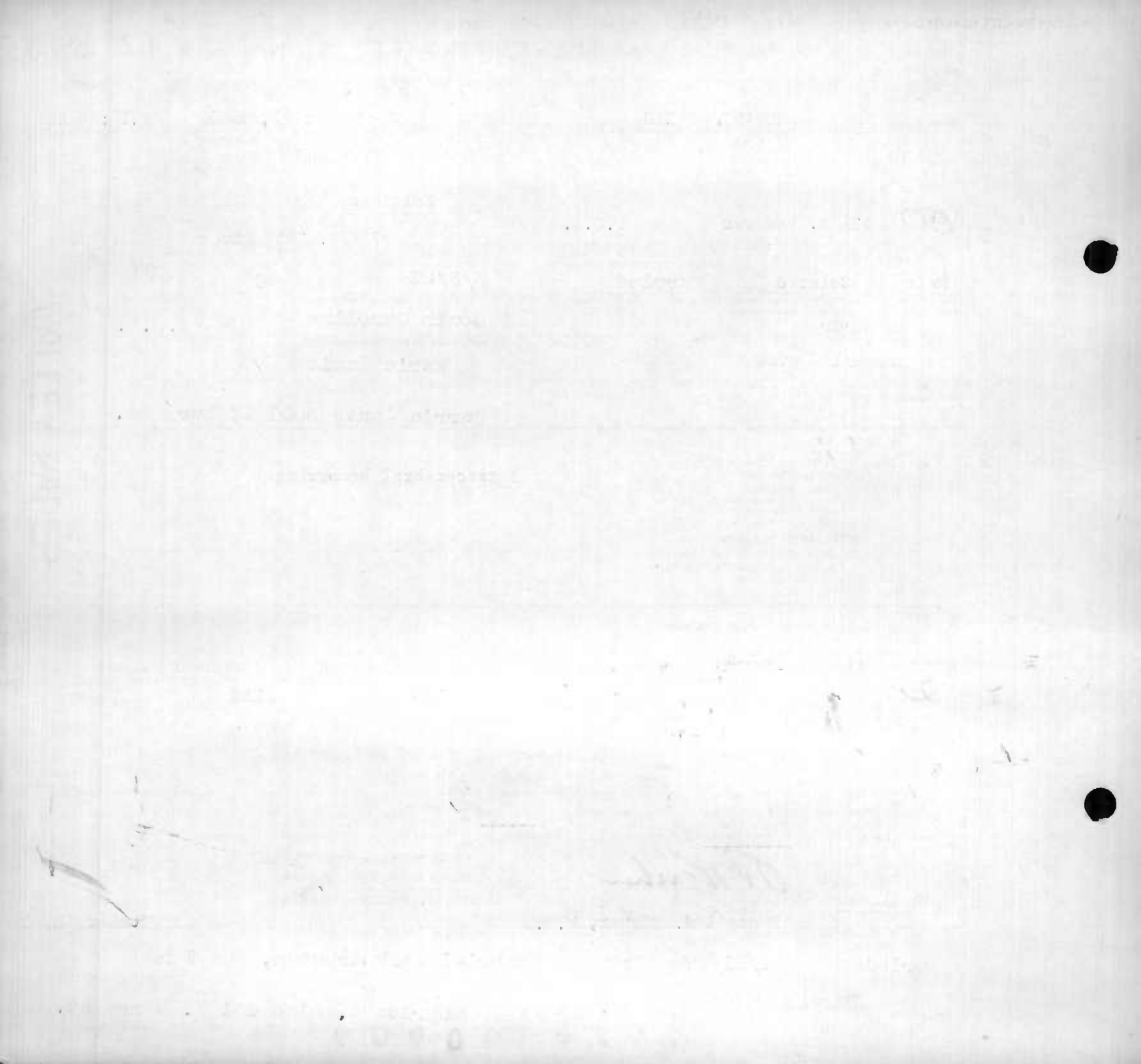
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 8940 CERTIFICATE OF DEATH					Registered No. 67 8940					
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					Ruth v Braithwaite			Sept. 16, 1967, 5:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Kenesae Nursing Home 2601 Roslyn Ave.					A. STATE Md. Baltimore					
(If not in hospital or institution, give street address or location)					B. COUNTY Baltimore					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
					D. STREET ADDRESS (If rural, give location) 523 Riverside Drive					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Female	White	Widowed		Mar. 22, 1896	71					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
H. Wife					Maryland			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Eden Brashear					Lavada Duckworth					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
no					Richard Braithwaite			523 Riverside Dr. Baltimore, Md. 21221		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					A) DUE TO			4 1/2 years		
ANTECEDENT CAUSES					B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					C) DUE TO					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 3/6 1965 to 9/16 1967, that (I) (we) last saw the deceased alive on 9/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE					23B. DATE SIGNED					
Robert A. Reiter					9/16/67					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
Robert A. Reiter					606 Edmondson Ave Baltimore Md 21228					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
Burial				Philos			Westernport, Md			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS		
SEP 19 1967			Robert E. Fickel		E. F. Bial			Westernport, Md.		

For the purpose of the present investigation, the following facts are presented:

The first fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

The second fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

The third fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

The fourth fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

The fifth fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

The sixth fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

The seventh fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

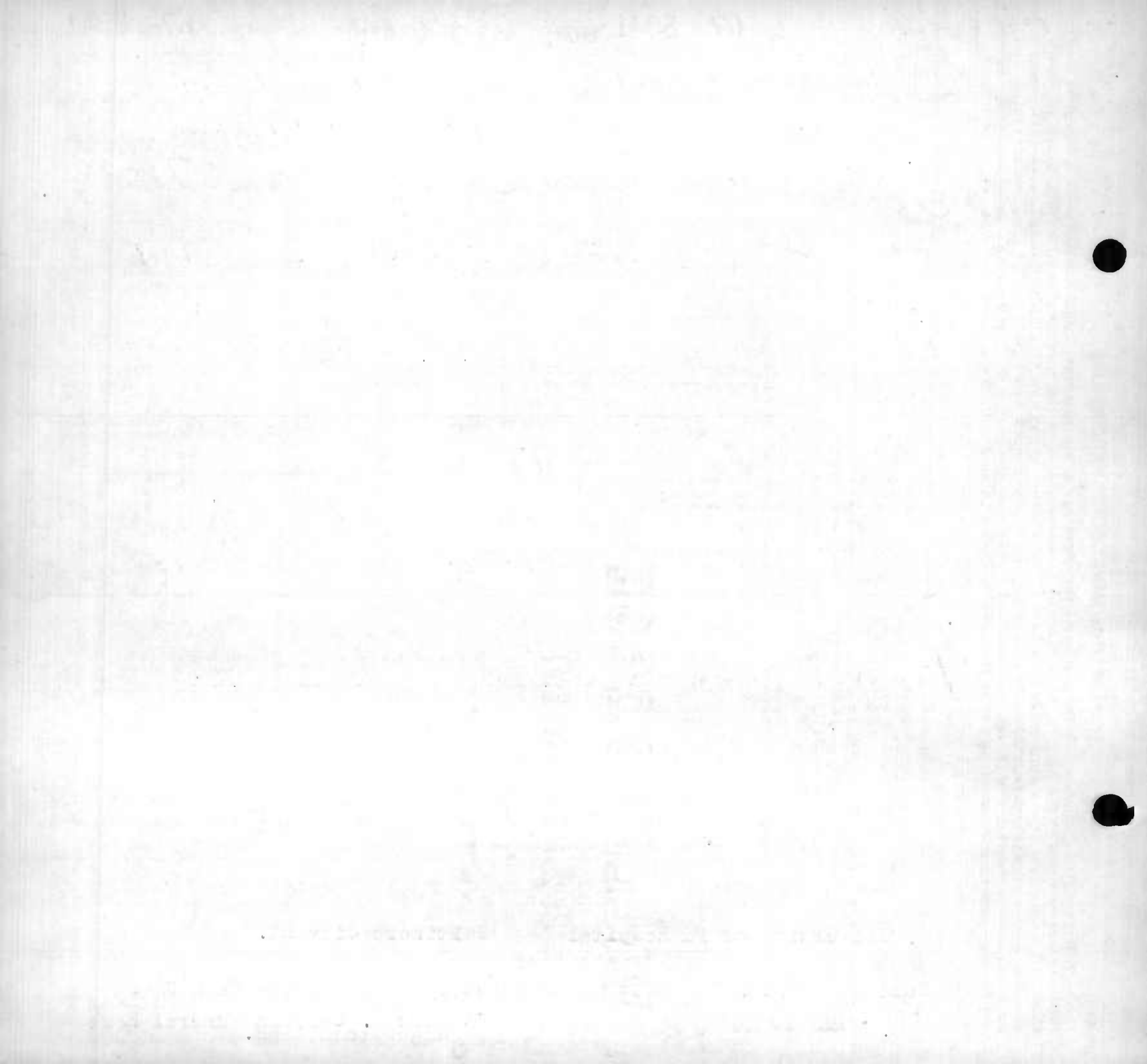
The eighth fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

The ninth fact is that the subject of the investigation is a person of the name of [Name] who is a resident of [Address].

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

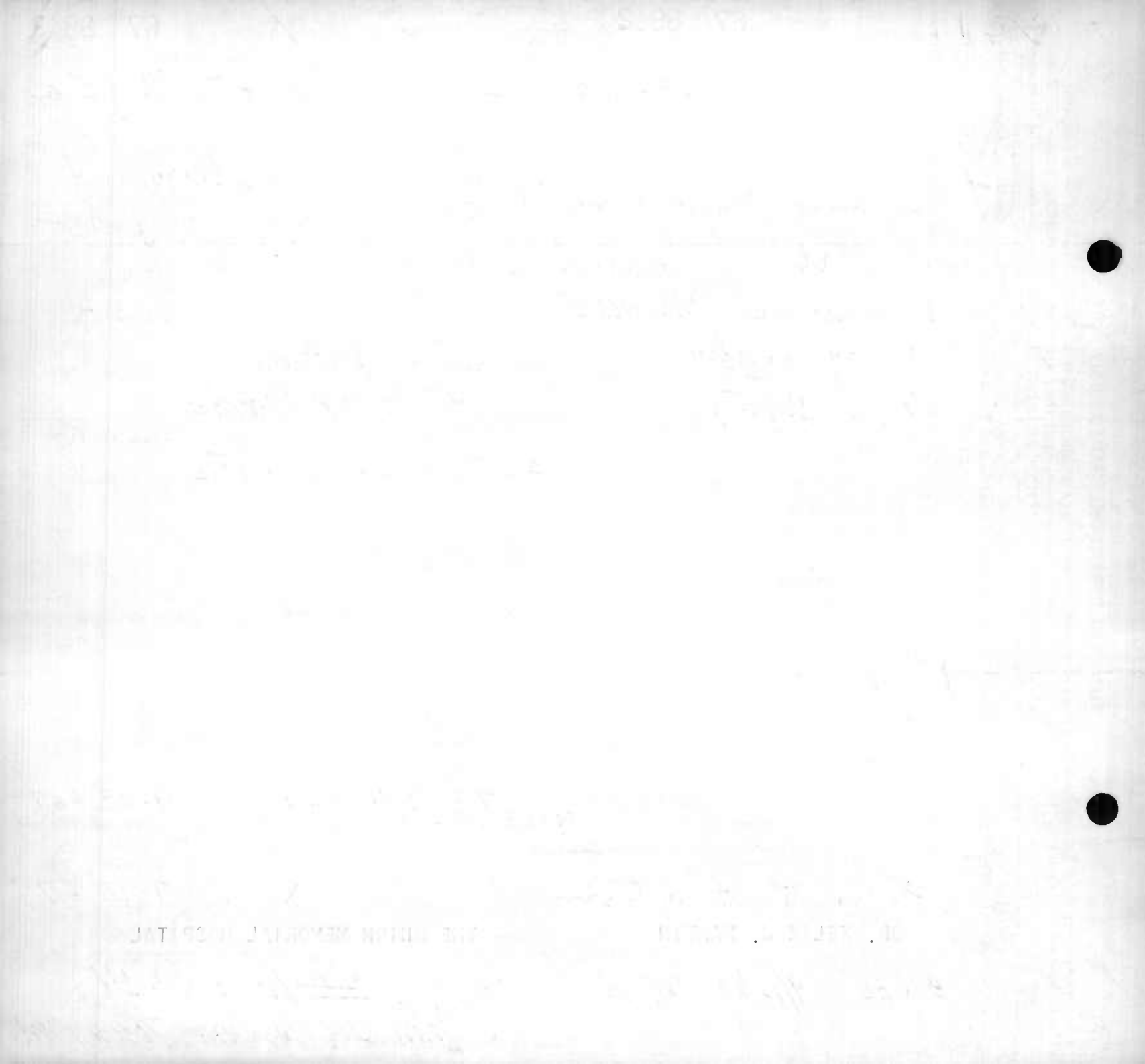
BIRTH NO. <u>Washington Co., Md. 67</u> <u>8941</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67</u> <u>8941</u>	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>LINDALOU EMBLY</u>			
2. DATE AND HOUR OF DEATH <u>9-16-67 12:55pm</u>				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSPITAL</u> <u>38</u>				A. STATE <u>MD.</u> B. COUNTY <u>WASHINGTON Co</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>SHARPSBURG</u> <u>71-00</u>			
D. STREET ADDRESS (If rural, give location) <u>RT. 1</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>8-5-67</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: <u>1</u> Days: <u>18</u>	If Under 24 Hrs. Hours: <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RAYMOND EMBLY</u>				14. MOTHER'S MAIDEN NAME <u>PATRICIA LOU TEETERS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMATION <u>HOSPITAL CHART</u>		ADDRESS	
18. <u>75-1-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>MEININGITIS</u> DUE TO (B) <u>HYDROCEPHALUS (INTERNAL)</u> DUE TO <u>NON COMMUNICATING</u> (C) <u>LUMBAR MENINGOMYELOCELE</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>PNEUMONIA</u>							
19A. DATE OF OPERATION <u>8-16-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>LUMBAR MENINGOMYELOCELE</u>		20A. AUTOPSY? (Yes or No) <u>?</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8-12-</u> <u>19 67</u> to <u>9-16</u> <u>19 67</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Josce M Boyd</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-16-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>University of Md Hospital</u>				23D. ADDRESS <u>Baltimore City Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/18/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Rest Haven Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>		25C. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

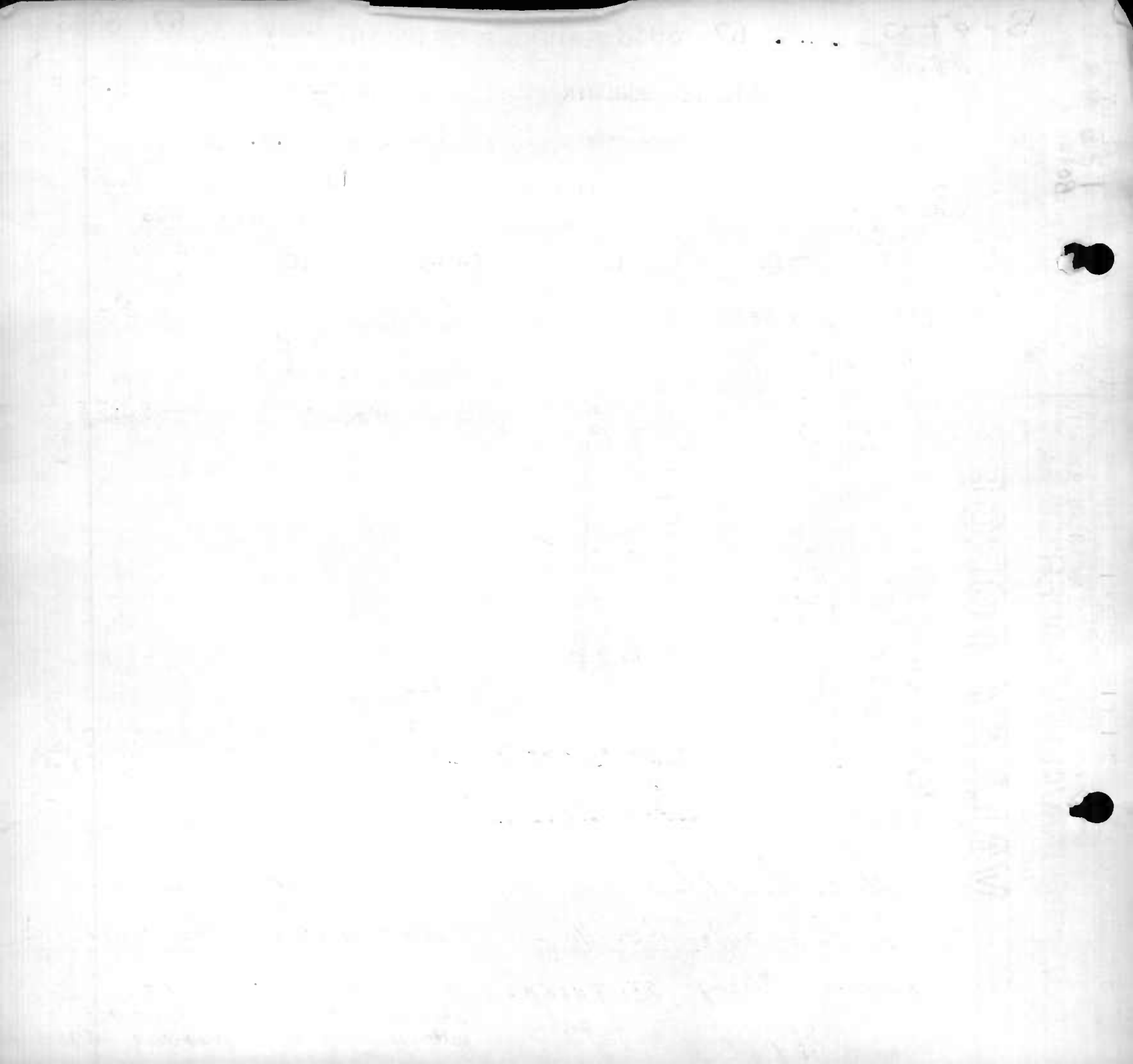
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8942	
BIRTH NO. 67 8942		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED <i>HIPPLE, ELEANOR L</i>		2. DATE AND HOUR OF DEATH <i>9-13-67 19:45 a.m.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i>		A. STATE <i>MD</i> B. COUNTY <i>Balts. Co</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Lutherville, Maryland</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>RT #1 Green Spring AVE</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>10-13-14</i>	9. AGE (In years last birthday) <i>53</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Harry Ledley</i>			14. MOTHER'S MAIDEN NAME <i>Lilly Hoffman</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Family Records</i>	
18. <i>571.1</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Acute & chronic colitis</i>			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>9-6-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Acute & chronic colitis</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-24-67</i> to <i>9-13-67</i> , that (I) (we) last saw the deceased alive on <i>9-13-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Felix J. Martin</i> M.D.				23B. DATE SIGNED <i>9-13-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. FELIX J. MARTIN</i> M.D.				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9/16/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Sater's Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Cocke Lutherville, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 19 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>John Brown's Son, Towson, Md.</i>			



THE BODY OF ZBIGHIEW BOROWIK HAS BEEN RELEASED FOR APPROVAL BY THE FUNERAL DIRECTOR: IMPORTANT EXAMINER'S OFFICE. This certificate must be approved by the chief medical examiner or his assistant if death occurred at a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8943		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8943	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ZBIGHIEW BOROWIK		9-15-67 9.55 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		MARYLAND A.A. C.		ANNAPOLIS 52-10	
		D. STREET ADDRESS (If rural, give location)		2721 LURY LA RIVA WOODS	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-6-31	9. AGE (In years last birthday) 36	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECT. ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY EACA CO		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME ALBERT		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 0		17. INFORMANT ALICE BOROWIK	
				ADDRESS ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9160 I CAUSE OF DEATH 50-60% Burn (20% 3rd deg)		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2721 Lury La Riva Woods ANNAPOLIS MD.	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 9 10 27 8:00		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Explosion Gas Range 52-10	
22. I certify that (I) (this hospital) attended the deceased from 9-10-1967 to 9-15-1967, that (I) (we) last saw the deceased alive on 9-15-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. C. Revilla				23B. DATE SIGNED 9-15-67	
23C. PHYSICIAN'S NAME (Type) A. Gonzalez-Revilla				23D. ADDRESS Johns Hopkins Hsg. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 9/16/67		24C. NAME OF CEMETERY or CREMATORY ST. THOMAS	
24D. LOCATION ARCHIBALD		24E. ADDRESS PA		25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967	
25B. NAME OF REGISTRAR P. B. B. B.		25C. FUNERAL DIRECTOR J. C. CONNELL SONS		25D. ADDRESS 302 MACE	
25E. NAME OF BURIAL		25F. ADDRESS ARCHIBALD PA.		25G. ADDRESS ARCHIBALD PA.	



CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Wilson A Hughes

2. DATE AND HOUR OF DEATH

9-15-67 3:45/A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

33-00

D. STREET ADDRESS (If rural, give location)

705

50th Street

21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9-6-1891

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

U.S. CIVIL SERVICE

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Elisha

14. MOTHER'S MAIDEN NAME

Arabella

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

W. W. I

16. SOCIAL
SECURITY NO.

213-07-4629

17. INFORMANT

ADDRESS

Records: BCM-4940 Eastern Avenue 21224

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Cardiac arrest.

DUE TO

(B) Metabolic Acidosis

DUE TO

(C) Acute renal shutdown.

2° previous cardiac arrest

+ levophed drip

MI.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-5 19 67 to 9-15 19 67.
that (I) (we) last saw the deceased alive on 9-15-67 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Mark Lowmiller

M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

9-15-67

23C. PHYSICIAN'S
NAME (Type)

Mark Lowmiller

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore,
Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

9/18/67

24C. NAME OF CEMETERY OR CREMATORY

MEADOWRIDGE

24D. LOCATION

(City, town, or county)

(State)

BALTO. M.D.

25A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

J. G. CONNELLY

ADDRESS

300 MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3

Compton Street

Not known for street

At the end of the street
is a small building
which is the
house of the
owner

101

Black & White
101-102
103-104

101-102

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8945	
BIRTH NO. 67 8945		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOSEPHINE A. FILLMORE		2. DATE AND HOUR OF DEATH SEPT. 18 1967 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 25-04			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 807 JEFFREY ST. BALTO.			
		D. STREET ADDRESS (If rural, give location) 807 JEFFREY ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) divorced	8. DATE OF BIRTH 9/12/1919	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender		10B. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A		13. FATHER'S NAME Garrison G. Boyle		14. MOTHER'S MAIDEN NAME Catherine Young	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-5348		17. INFORMANT David Kreutzberg - 2104 Patapsco Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF CERVIX		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 YEARS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if at this hospital) attended the deceased from 7-10 1967 to 9-18 1967 , that (if we) last saw the deceased alive on 9-18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irving L. Cooperstein		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-18-67	
23C. PHYSICIAN'S NAME (Type) IRVING L. COOPERSTEIN		M.D. 23D. ADDRESS MONTEBELLO STATE HOSPITAL, BALTO.-MD.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/67		24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cemetery Rt # 40 - Toward Co. Ind.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md. (21223)		25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Tarkenton	
25C. FUNERAL DIRECTOR John J. Cowan & Son, Inc. 901 Hollins St. Balto. Md.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8946				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8946	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				(Type or Print)		(Type or Print)	
				John Joseph Kramer (KRAEMER)		9/17/67 8:30 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
38 UNIVERSITY HOSPITAL				Md. Baltimore 21202			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH 9. AGE (In years lost birth)			
Male W Never married				8/31/63 64			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Part time Bell Sun Papers Co.				Baltimore Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frederick Kramer				Bertha Wave			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				212-016779			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				19. CAUSE OF DEATH			
162.1 I				(A) BRONCHAGENIC CA			
ANTECEDENT CAUSES				(B) PNEUMONIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				20A. AUTOPSY? (Yes or No)			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 31 1967 to SEPTEMBER 17 1967, that (I) (we) last saw the deceased alive on SEPTEMBER 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
M. D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>				9/17/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MERAE W. Williams				UNIVERSITY OF MARYLAND HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/20/67		Western Cem.		Edmondson + Longwood Sts.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 19 1967		Robert E. Jackson		John J. Lynam & Son Inc.		213 - Md.	

604 Washington Blvd.

Walt W. Reed, Owner 2/23/64

First National Bank & Trust Co. - Seattle, Wash. U.S.A.

Frank Brown, Treasurer

012-04-0111 Mr. William Johnson - Seattle, Wash.

Back 8/20/61 - Western Bank
Prof. James W. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Hochrein, Alice A		2. DATE AND HOUR OF DEATH 9/17/67 8:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
H4 Union Memorial Hosp		Baltimore		7419 Old Harbor Rd.	
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 4-14-1878	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME OLIVER		14. MOTHER'S MAIDEN NAME ELiza ARINGER		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 22054 8295 J 1		17. INFORMANT ADDRESS Hospital Records	
18. 133.01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Branchiopneumonia			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Pleural effusion			
		(C) DUE TO			
		Cystic carcinoma			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/19/67 to 9/17/67, that (I) (we) lost saw the deceased alive on 9/12/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. H. H. H.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/17/67	
23C. PHYSICIAN'S NAME (Type) H. H. H. H.		23D. ADDRESS 322 Stevenson Lane			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-21-67		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD	
24D. LOCATION BALTIMORE Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Stephens		25C. FUNERAL DIRECTOR ADDRESS Spas. F. EVANS & Son 8802 Hartford Rd	

Handwritten notes at the top of the page, including the word "Horse" and some illegible scribbles.

4/11/28

25024 2222 11

~~Handwritten text, possibly a signature or name, crossed out with a horizontal line.~~

Handwritten signature or name, possibly "J. J. ...", written in a cursive style.

Handwritten notes at the bottom of the page, including dates like "4/11/28" and "4/12/28", and some illegible text.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	67 8948
BIRTH NO.		67 8948		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. ISABELLE GLOVER		2. DATE AND HOUR OF DEATH Sept. 17, 1967 12:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto. Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home + Hospital 35		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 3331 Wilkings Rd	
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 5-10-84	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Seamstress		11. BIRTHPLACE (State or foreign country) SWITZERLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Biser		14. MOTHER'S MAIDEN NAME Maria Donna	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 051-28-8226		17. INFORMANT Hospital	
18. 526X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) Pneumonia, Right lung DUE TO			
ANTECEDENT CAUSES		(B) chronic Bronchitis DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pulmonary congestion	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <u>hospital</u>) attended the deceased from <u>9/15</u> 19 <u>67</u> to <u>9/17</u> 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9/17</u> 19 <u>67</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.					
23A. SIGNATURE W. S. S. S.				23B. DATE SIGNED 9/17/67	
23C. PHYSICIAN'S NAME (Type) VENITA SUAREZ		23D. ADDRESS Church Home + Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-20-67		24C. NAME OF CEMETERY or CREMATORY GATE OF HEAVEN	
24D. LOCATION (City, town, or county) (State) Westchester Co. N.Y.		25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robt. E. Taylor	
25C. FUNERAL DIRECTOR CO. F. EVANS		25D. ADDRESS 8802 HANCOCK Rd			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8949	
BIRTH NO. 67 8949		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EMMA MITCHELL		2. DATE AND HOUR OF DEATH 9/15/67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION MIDTOWN HOME 808 ST. PAUL ST.		A. STATE MD B. COUNTY BALTO.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE		53-00	
		D. STREET ADDRESS (If rural, give location) FAIRVIEW AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 5/25/83	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOIVE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WISCONSIN	
13. FATHER'S NAME W.M. KRUEGER		14. MOTHER'S MAIDEN NAME ALBERTA YEAGER		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ANNA TITUS	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiovascular failure DUE TO ant curd (B) Gen. Arteriosclerosis DUE TO Senility (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (I APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 1962 to Sept 15 1967 , that (I) (we) last saw the deceased alive on Sept 15 1967 and that in (my) four opinion death occurred on the date and hour and from the causes stated above. (I) (initials) (did not) view the body after death.					
23A. SIGNATURE William Applefeld M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William Applefeld		23D. ADDRESS 5501 Park Heights Dr.			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 9/18/67		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION (City, town, or county) (State) BALTO. MD					
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR F.S. MACNABB	
				ADDRESS 301 FREDERICK RD 21228	

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67 8950 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8950

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN W. ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1967 2:40 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 920 N. Calvert D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 11-01

D. STREET ADDRESS (If rural, give location)

920 N. Calvert St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

July 2, 1883

9. AGE (In years last birthday)

84

If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Night Watchman-Cambridge Iron & Steel

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Francis Robinson

14. MOTHER'S MAIDEN NAME

Anna Trogeser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

WW 1 - Army

16. SOCIAL SECURITY NO.

218-10-5166

17. INFORMANT

2983 Erdman Ave. Howard J. Robinson, nephew

18.

422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 18, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/20/67

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat. Cem.

23D. LOCATION

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

24B. NAME OF REGISTRAR

Russell S. Fisher

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc. 3331 Brehms Lane

ADDRESS

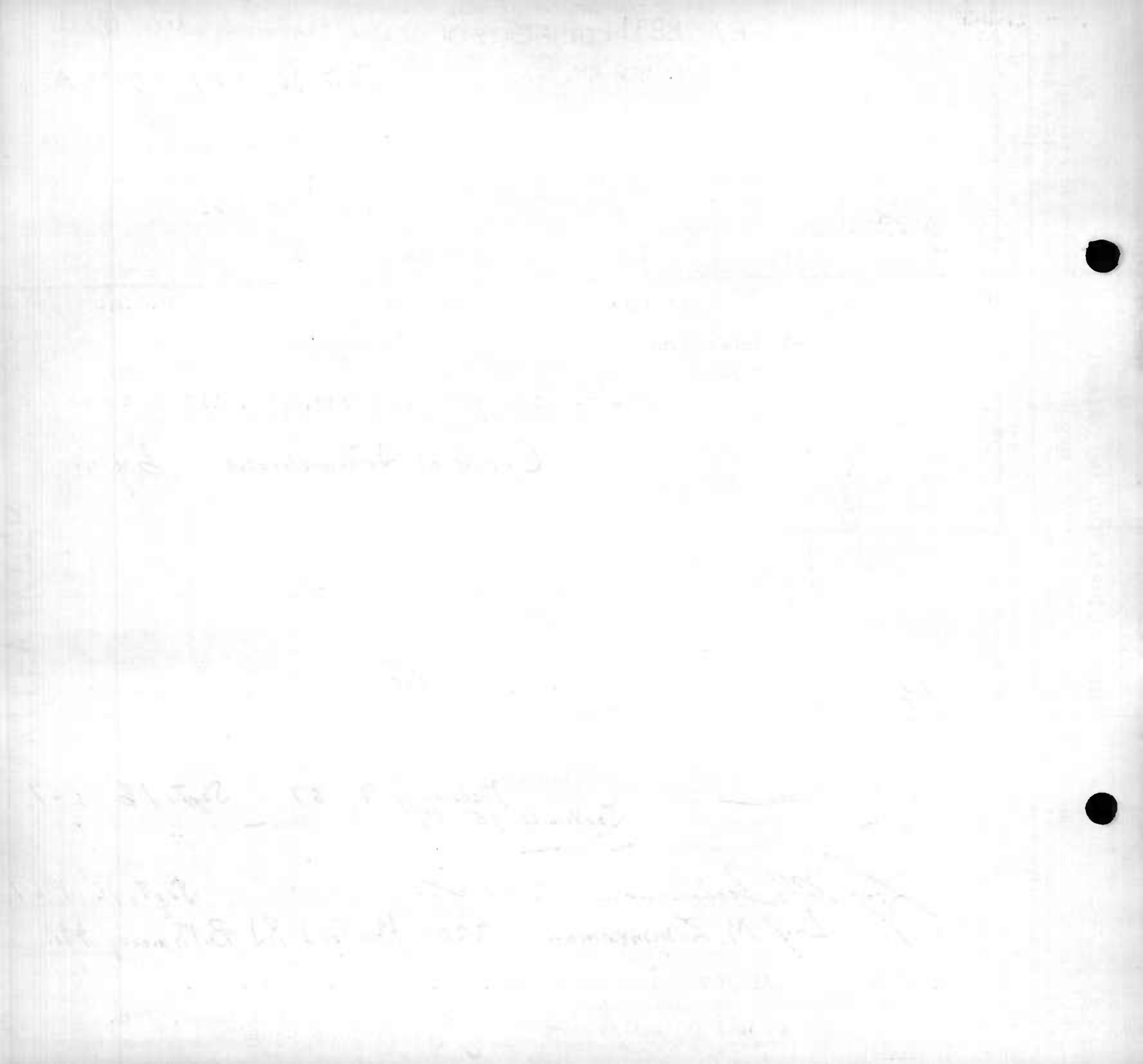
WILLIE FORGE

JOSEPH A. JENSEN

W. H. H. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8951				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8951	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				FLORENCE E. SCHOEN		Sept. 16, 1967 7:25 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
90 Harford Gardens Nursing Home				Md., 21213			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 26-02	
				D. STREET ADDRESS (If rural, give location)		4260 Sheldon Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
female	white	married	3/8/85	82	Housewife		England
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			at home		England		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Daniel Henderson				Annie Buckbe			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				216-05-8350B		Anna May Kirby, dght, 3110 Kentucky Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
334X I				Cerebral Arteriosclerosis		5 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from February 9 1967 to Sept. 16 1967. that (I) (we) last saw the deceased alive on September 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Loy M. Zimmerman						Sept. 16, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Loy M. Zimmerman				3202 Harford Rd, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/18/67		Immanuel Luth. Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 19 1967		Robert E. Starkey		Schimunek Funeral Home, Inc.		3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

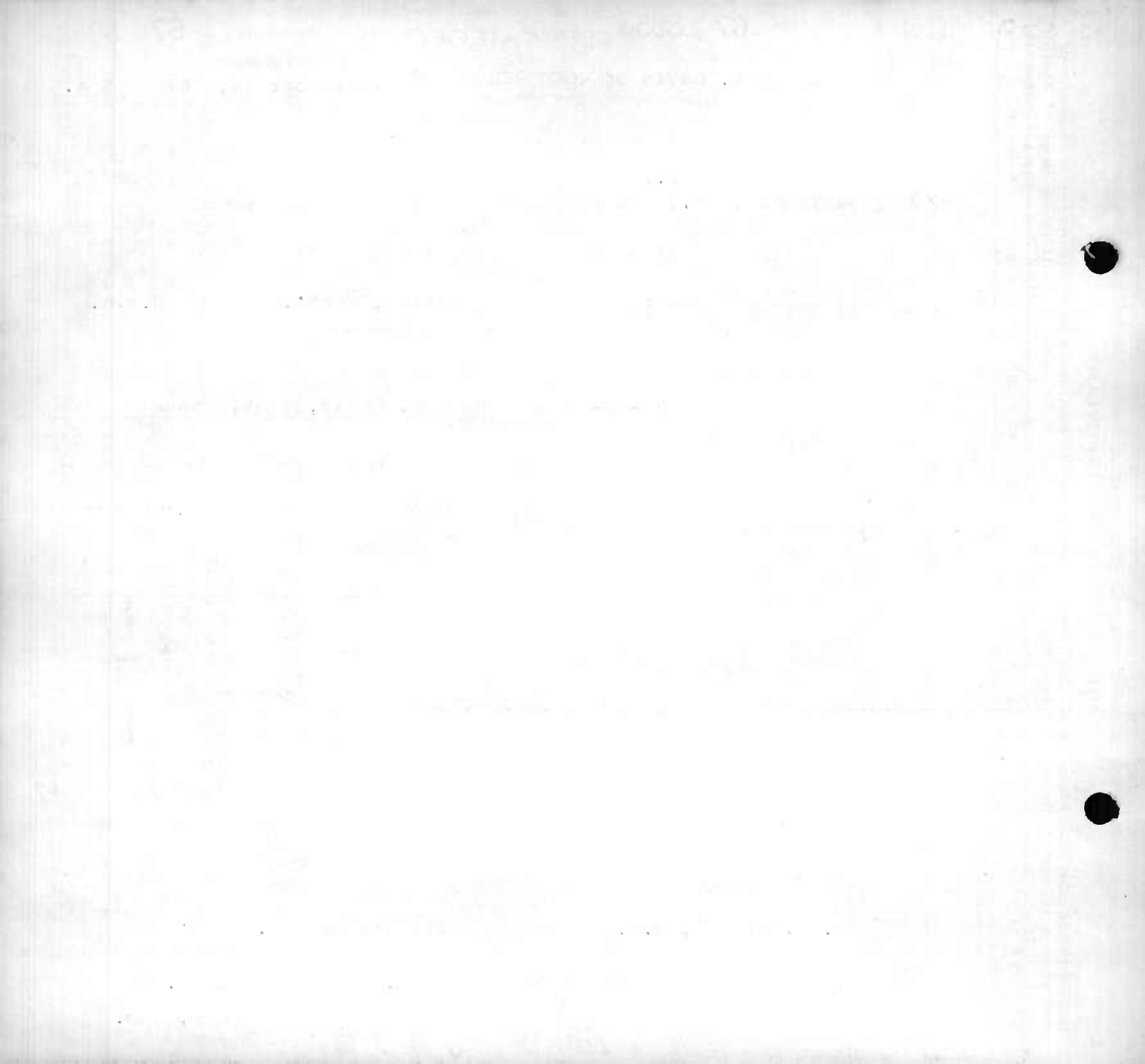
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 8952		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 8952	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		MARY ELIZABETH EYRING		17 SEP 67		8 39 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Md. 21213					
34 Mercy Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore		8-01	
				D. STREET ADDRESS (If rural, give location)		2223 Chesterfield Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	
F	W	widowed	5/7/93	74					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		at home		Baltimore, Md.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT		ADDRESS			
John L. Matteu		Laura Brehm		4 Ruxton Ridge Garth, 21204		Edward E. Eyring, Sr.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
		217-46-0084		Edward E. Eyring, Sr.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		ACUTE MYOCARDIAL INFARCTION		3 days			
ANTECEDENT CAUSES		(B) DUE TO		ARTEROSCLEROTIC HEART DISEASE					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
N/A		N/A		NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
N/A		N/A		N/A					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
N/A		While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		N/A					
22. I certify that (this hospital) attended the deceased from		14 SEP 1967		17 SEP 1967		19 67			
that (we) lost saw the deceased alive on		16 SEP 19 67		and that (our) opinion death occurred on the date					
and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE		M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
SALVATORE R. DONOHUE		M.D.		MERCY HOSPITAL, BALTO, MD		17 SEP 67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
SALVATORE R. DONOHUE		MERCY HOSPITAL, BALTO, MD							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		9/20/67		Holy Redeemer Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
SEP 19 1967		R. E. Eyring		Schimunek Funeral Home, Inc.		3334 Brehms Lane			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 67 8953		REGISTERED NO. 67 8953	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MARIE L. DAVIS or KOCOUREK			2. DATE AND HOUR OF DEATH September 15, 1967 5 a. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 4609 Furley Ave., Baltimore, Md., 21206			A. STATE Md. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-02		
			D. STREET ADDRESS (If rural, give location) 4609 Furley Avenue		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8/14/1891	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria worker		10B. KIND OF BUSINESS OR INDUSTRY Bendix	11. BIRTHPLACE (State or foreign country) Vinarice, Czech.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 220-22-2835A		17. INFORMANT ADDRESS Vera M. Davis, dght, above
18. 334 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Arteriosclerotic cerebral disease DUE TO (B) Arteriosclerotic cardiovascular disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 years 3 mo
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 18 1954 to Sept 15 1967 , that (I) (we) last saw the deceased alive on Sept 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. J. Alessi, M.D.				23B. DATE SIGNED 9/16/67	
23C. PHYSICIAN'S NAME (Type) E. J. Alessi, M.D.				23D. ADDRESS 6217 Harford Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/67		24C. NAME OF CEMETERY or CREMATORY Bohemian National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 8954		67 8954	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		HARNER HALLIE LEE		SEPT 18 1967 12:40A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
40 ST AGNES HOSPITAL CATON & WILKENS AVE BALTO 21229 MD				MARYLAND Baltimore	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)	
BALTO - Dundalk				3441 LIBERTY PKWY	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	MARRIED	1/21/99	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		NONE		WEST VIRGINIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thornton F. Martin			Mary ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		ST AGNES ADMIS. SLIP	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from SEPT 15 19 67 to SEPT 18 19 67, that (X) (we) last saw the deceased alive on SEPT 18 19 67 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
L. George Angov M.D.				9/18/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
GEORGE ANGOV				ST AGNES HOSP WILKENS & CATON BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		9/20/67		Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 19 1967		Robert E. Taylor, M.D.		John J. Duda, 7922 Wise Ave. Dundalk, Md.	

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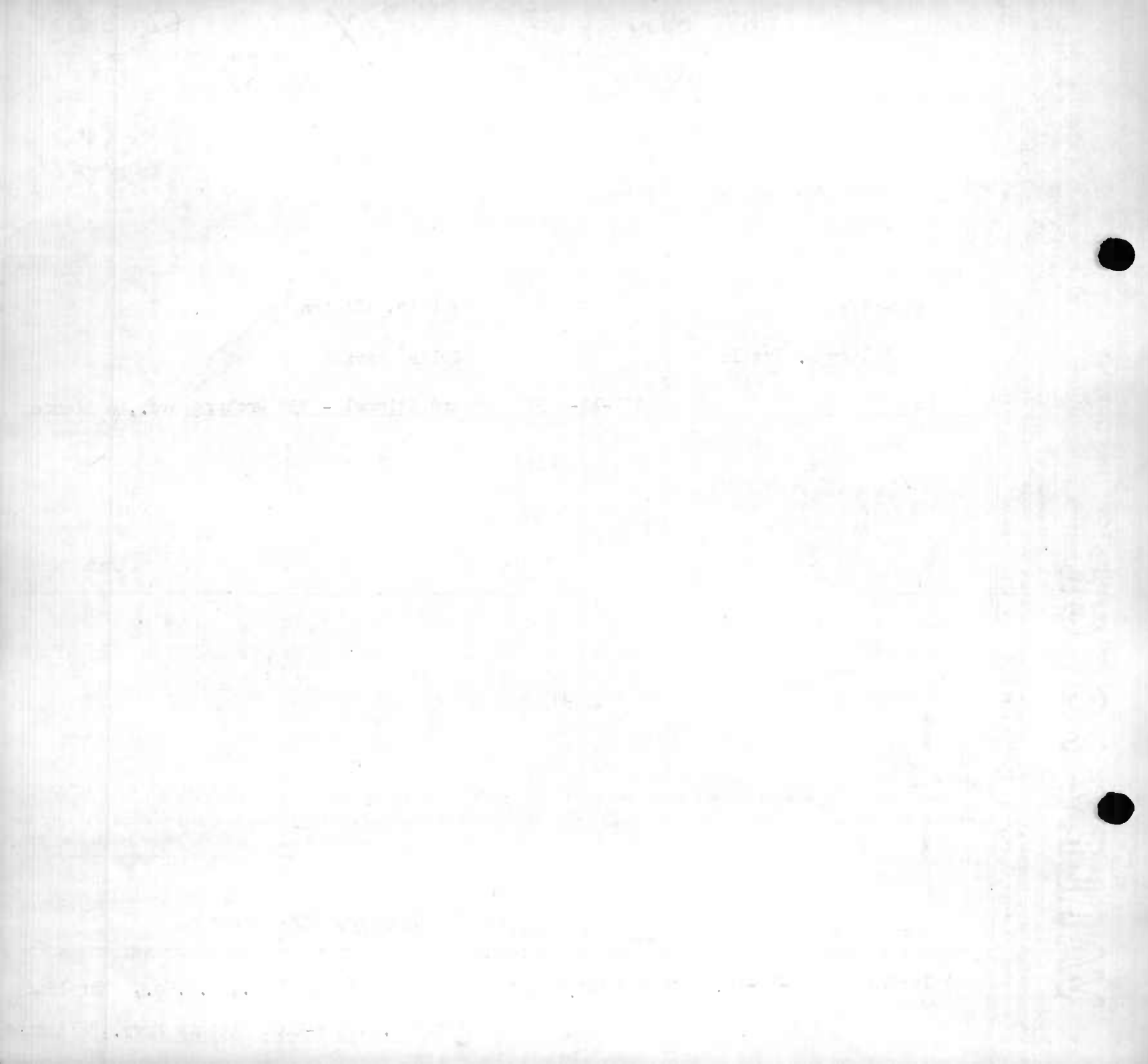
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8955	
BIRTH NO. 67 8955		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) STIMMEL, MARY		2. DATE AND HOUR OF DEATH 9/13/67 5:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 9.9.C. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 330 ORCHARD AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-14-95	9. AGE (In years last birthday) 71 YRS	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Mobile, Alabama		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William H. Tuttle			14. MOTHER'S MAIDEN NAME Julia Chavana		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 277-12-0837	17. INFORMANT ADDRESS Edward Stimmel - 330 Orchard Ave., Baltimore		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) VENTRICULAR FIBRILLATION (A) DUE TO		CAUSE OF DEATH HYOCARDIAL INFARCTION (B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH MINUTES	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD (C) DUE TO				DAYS YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/17 19 67 to 9/13 19 67 , that (I) (we) last saw the deceased alive on 9/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Queral				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) FERNANDO QUERAL				23D. ADDRESS M.D. LUTHERAN HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-16-1967	24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hwy., A.A.Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce-4001 Ritchie Hwy., Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-18945</u> <u>67</u> <u>8956</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67</u> <u>8956</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Hoff, Baby Boy</u>		2. DATE AND HOUR OF DEATH <u>9/17/67</u> <u>9:20</u> A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u> <u>33 Balto, Md 21205</u>		D. STREET ADDRESS (If rural, give location) <u>2801 Homewood Ave</u>		9-05	
5. SEX <u>M</u>	6. RACE <u>N.C.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>INFANT</u>	8. DATE OF BIRTH <u>9/15/67</u>	9. AGE (In years lost birthday) <u>2</u>	If Under 1 Yr. Months: <u>2</u> Days: <u>2</u> Hours: <u>0</u> Min. <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard</u>		14. MOTHER'S MAIDEN NAME <u>Arlene Miller</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>762.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>Respiratory Distress Syndrome</u> DUE TO (B) <u>Cerebral Anoxia and Fetal Distress</u> DUE TO <u>in utero</u> (C) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>37 hrs</u> <u>37 hrs</u> <u>37 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>SEPT 16 at 8:00 AM</u> 19 <u>67</u> to <u>SEPT 17 at 9:00 A</u> 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>SEPT 17 at 9:00 A</u> 19 <u>67</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death.					
23A. SIGNATURE <u>Stephen H. Polmar</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>Sept 17, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>STEPHEN H. POLMAR</u>		23D. ADDRESS M.D. <u>JOHNS HOPKINS HOSPITAL BALT. M.D.</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fairman</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>			
ADDRESS					

Hoff, Baby Boy
John Hopkin Hospital
Baltimore, Md 21202

M. H. Infant

Richard.

2801 Homewood Ave
Baltimore, Md 21202
Plister ..

Arlene Miller
Baltimore, Md 21202
U.S.A.

yes

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No 67 8957

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD Mc CONNELL

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1967 1:55 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2415 Barclay St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Nov. 5, 1918

9. AGE (in years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Mattie Love

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-01-9290

17. INFORMANT

ADDRESS

Mattie Frederick 2415 Barclay St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Arteriosclerotic
DUE TO Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/21/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Cty., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

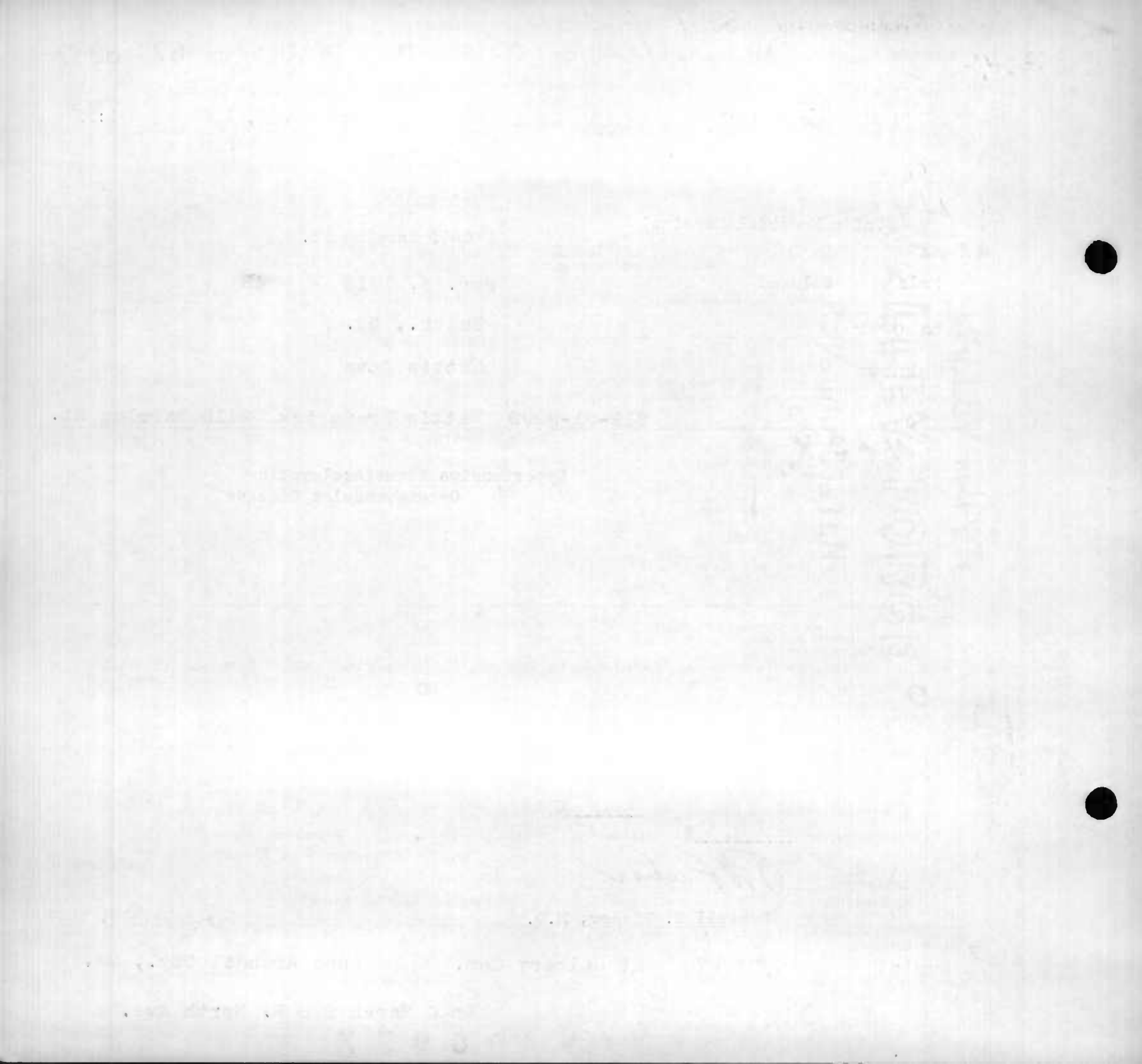
24C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1967

R. S. Fisher

Wm C March 928 E. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 8958		67 8958	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CLINTON, JOHN HENRY			9-15-67 5:30PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229			MARYLAND Baltimore Co		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			REISTERSTOWN 53-00		
			D. STREET ADDRESS (If rural, give location)		
			RT # 3 - BOX 145 A		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	MARRIED	3-1-1902	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
RETIRED farmer		laborer	PENNSYLVANIA		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN CLINTON			BARBARA BERKINHIZER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMATION		
UNKNOWN No		216 28 2542	WILKENS & CATON AVES. BALTO., MD. ST. AGNES HOSPITAL RECORDS 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		6 Mo.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 5 19 67 to SEPTEMBER 15 1967, that (I) (we) last saw the deceased alive on SEPTEMBER 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
RAYMOND J. D. BARR M.D.			9/16/67		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
RAYMOND J. D. BARR M.D.			ST Agnes Hosp		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	9/19/67	Linganore Cemetery	Unionville Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
SEP 19 1967	Robert E. Taylor M.D.	D. J. Taylor & Sons		NEW WINDSOR	

1000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print) LEONARD

LARK

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1967 11:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
 HOSPITAL OR ADDRESS OR LOCATION
 9-29-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1010 W. Barre St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Jul 29, 1904

9. AGE (In years
last birthday)

62 63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bulldozer Operator

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S. A

13. FATHER'S NAME

George Lark

14. MOTHER'S MAIDEN NAME

Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-14-8254

17. INFORMANT

ADDRESS

Mrs. Lacy M. Clark 3315 Hayward Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/18/67

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Frank J. Seitz 814 436 7111

ADDRESS

CERTIFICATE AMENDED

WATKINS PAPER
WATKINS FORGE
WATKINS

J-520

67 8960

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8960

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SHIRL

JAMES

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1967 10:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 10 E. Pratt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

10 E. Pratt St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct-11-1925

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W. Virginia

12. CITIZEN OF
WHAT COUNTRY

USA

13. FATHER'S NAME

Rensy James

14. MOTHER'S MAIDEN NAME

Simon Simmons

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

23532-5384

17. INFORMANT

MAXINE W. Gilbert 25 - Village Green
(Middle River)

18.

465 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Massive Pulmonary Embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/16/67

23C. NAME OF CEMETERY or CREMATORY

Garden of Faith

23D. LOCATION

(City, town, or county)

(State)

4449 - Kenwood Ave.

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Thos. Leo Fisher 1930 Eastern Ave.

WILLIAM L. B. POPE

WILLIAM L. B. POPE

WILLIAM L. B. POPE

WILLIAM L. B. POPE

WILLIAM L. B. POPE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department										
67 8961					67 8961					
BIRTH NO.					Registered No.					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) VIGER, LOUIS JOSEPH L.					2. DATE AND HOUR OF DEATH 9-16-67 2:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 35 CHURCH HOME AND HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2-03 D. STREET ADDRESS (If rural, give location) 2000 FOUNTAIN STREET					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED		8. DATE OF BIRTH 7-1-1901		9. AGE (In years last birthday) 66 yrs.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		10B. KIND OF BUSINESS OR INDUSTRY SHIPPING		11. BIRTHPLACE (State or foreign country) NEW BEDFORD MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? AMERICAN				
13. FATHER'S NAME PHILLIP VIGER					14. MOTHER'S MAIDEN NAME E. MORIAN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 026-09-5019		17. INFORMANT LOUIS J. VIGER					ADDRESS RT. 1 360 D. LADSON S. CAROLINA	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PORTAL Cirrhosis ANTECEDENT CAUSES CHRONIC ALCOHOLISM DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					INTERVAL BETWEEN ONSET AND DEATH YEARS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 9-5 1967 to 9-16 1967, that (I) (we) lost saw the deceased alive on 9-16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Ephraim Barzaga M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 7-16-67		
23C. PHYSICIAN'S NAME (Type) Ephraim BARZAGA M.D.					23D. ADDRESS CHURCH HOME & Hosp - BALTO. 31, Md					
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE SEPT 20, 1967		24C. NAME OF CEMETERY or CREMATORY ST. MATTHEW'S CEM.			24D. LOCATION (City, town, or county) (State) BALTO. MD			
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967			25B. NAME OF REGISTRAR Ed. J. ...			25C. FUNERAL DIRECTOR DIPPEL BRO'S INC 1800 E LOMBARD ST.			ADDRESS	

CHURCH HOME AND HOSPITAL

WAGE WHITE EMERGENCY

GERMAN

PHILIP VIGOR

and of the

2011-11-11

11-11-11

11-11-11

11-11-11

11-11-11

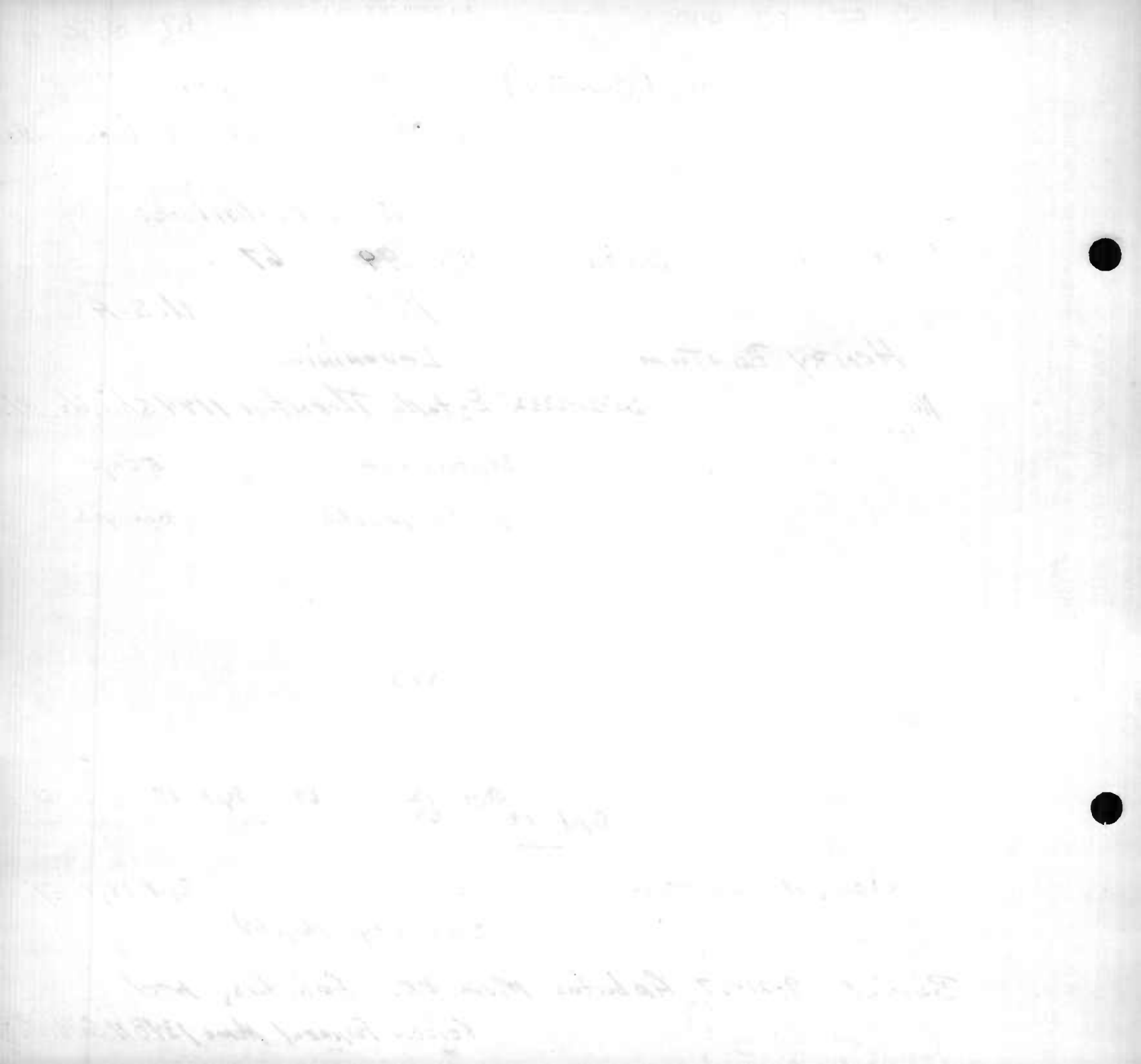
11-11-11

11-11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 8962		CERTIFICATE OF DEATH		67 8962	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Alverta Simms (Bantum)</i>			<i>September 18 67 9:00 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> <i>38</i>			A. STATE <i>Md.</i> B. COUNTY <i>Crownsville</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>		
			D. STREET ADDRESS (If rural, give location) <i>3306 Burlingame Ave.</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>10/21/99</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>HENRY Bantum</i>			14. MOTHER'S MAIDEN NAME <i>Leveninia</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-21-6332</i>	17. INFORMANT <i>Estella Thornton</i>		ADDRESS <i>1144 Shields Pl.</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>600.0 I</i>			CAUSE OF DEATH (A) <i>Septicemia</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Pyelonephritis</i> DUE TO		<i>one year</i>
			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 12</i> 19 <i>67</i> to <i>Sept 18</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Sept 18</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Gary M. Lattin</i>				23B. DATE SIGNED <i>Spt 18, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>GARY M. LATTIN</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-21-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. Pk.</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 19 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Kafsan Funeral Home</i>	
				ADDRESS <i>1348 N. Calhoun St.</i>	



1 520

67 8963

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 8963

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES INSEY

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1967 10:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 927 N. Stricker St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

927 N. Stricker St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4/11/

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Annapolis Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Lorene Insey, same

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH?

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/21/67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1967

Robert E. Fisher, M.D.

Adolphus Halstead 1206 W North Ave

WALLLEY HORSE
25/RAE CURRENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8964		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8964	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) JAMES EDWARD BUTLER					
2. DATE AND HOUR OF DEATH 9-13-67 10:26 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITAL 4940 Eastern Avenue Baltimore, Md. #21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12 04 D. STREET ADDRESS (If rural, give location) 1924 GREENMOUNT AVE		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-25-35	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. C North Carolina	
13. FATHER'S NAME WILLIAM (William)			14. MOTHER'S MAIDEN NAME BESSIE (Bessie)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-20-0624		17. INFORMANT ADDRESS BCN 4940 Eastern Avenue Baltimore, Maryland #21224	
18. 587.0 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) RESPIRATORY ARREST DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 Hrs 16 MIN
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) SHOCK DUE TO		3 DAYS 2 1/2 Hrs
			(C) HEMORRHAGIC PANCREATITIS		MORE THAN 4 DAYS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible Pneumonia					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-9 19 67 to 9-13 19 67 , that (II) (we) last saw the deceased alive on 9-13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Cordes M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9-13-67	
23C. PHYSICIAN'S NAME (Type) Robert A. Cordes		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/67		24C. NAME of CEMETERY or CREMATORY National Cemetry	
				24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print) RAY EPPS (Raymond Epps)		2. DATE AND HOUR OF DEATH 9-17-67 4³⁰ P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1000 N EDEN ST			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-15-11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CREWE, VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SCOT EPPS		14. MOTHER'S MAIDEN NAME LAURA GUY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Thelma Epps 1000 N. Eden St	
18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARDIAC ARRHYTHMIA DUE TO (B) DUE TO (C) CHRONIC RENAL FAILURE		INTERVAL BETWEEN ONSET AND DEATH 5 mos	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-15 19 67 to 9-17 19 67 , that (I) (we) last saw the deceased alive on 9-17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Myron John Adams, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9-17-67	
23C. PHYSICIAN'S NAME (Type) MYRON JOHN ADAMS, JR. M.D.		23D. ADDRESS JOHNS HOPKINS HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 20/67		24C. NAME OF CEMETERY or CREMATORY Crofton Virginia	
24D. LOCATION (City, town, or county) (State) 1129 N. Caroline ST		25A. DATE REC'D BY HEALTH DEPT. SEPT 19 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR John P. Ely			

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F-425

67 8966 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8966

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MINERVA ROBINSON (Nee Faulcon)

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1967 11:55 pm.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1515 N. Bruce St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2036 W. Lanvale St.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

Nov. 22, 1941 25

9. AGE (In years last birthday)

10 Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse

10B. KIND OF BUSINESS OR INDUSTRY

CONValescent

11. BIRTHPLACE (State or foreign country)

BALTO, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

GARRETT FAULCON

14. MOTHER'S M maiden NAME

ALICE WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ALICE FAULCON

ADDRESS

2029 W. LANVALE

18.

6450

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture ectopic pregnancy

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL SIGNATURE

Russell S. Fisher

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

September 18, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

9-21-67

23C. NAME of CEMETERY or CREMATORY

W. Calvary Cem

23D. LOCATION

AA. County

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

William E. Elchman

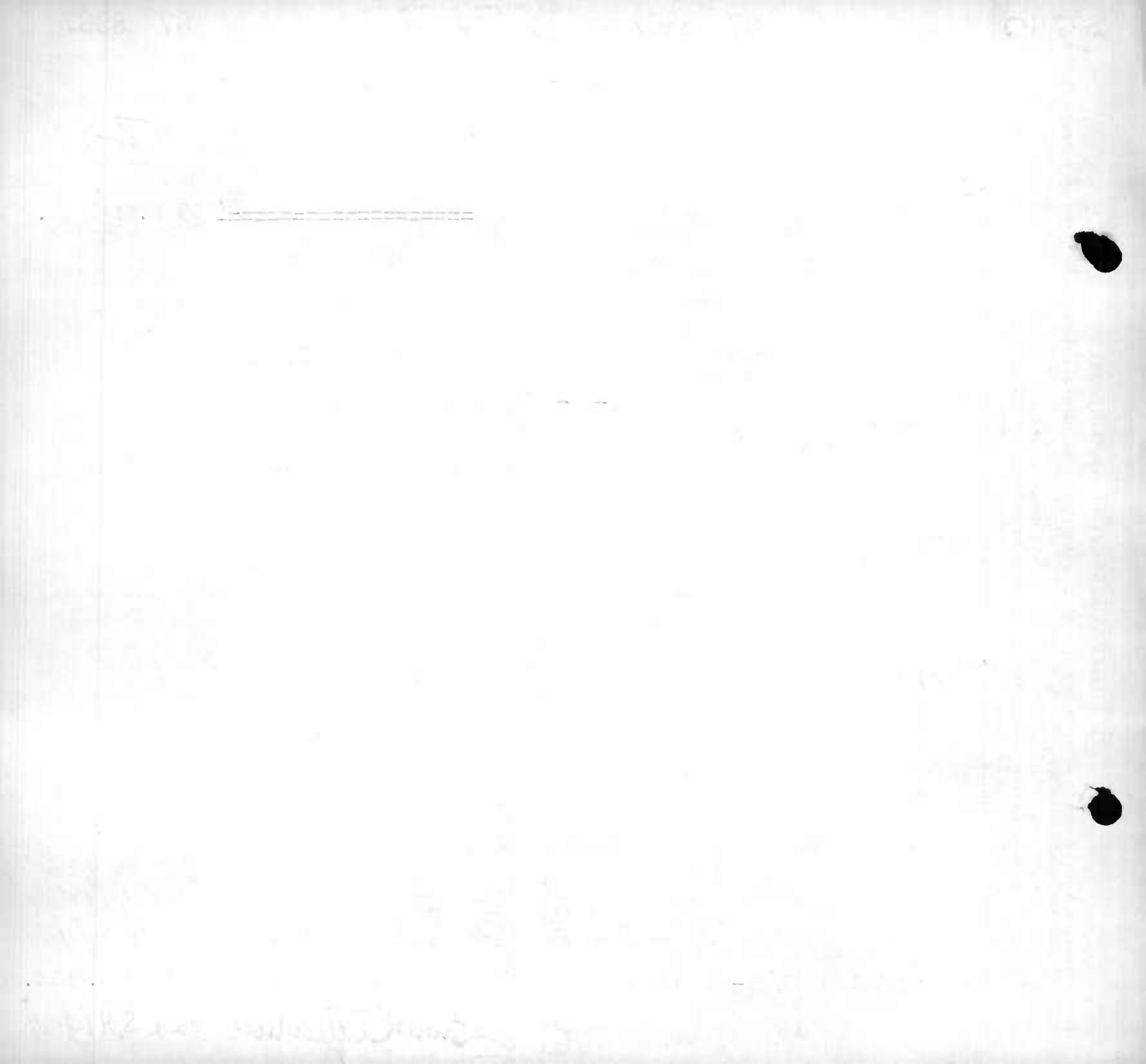
ADDRESS

1129 N. Caroline St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8967		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8967	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SAM-SAMUEL NICHOLAS BACCALA		2. DATE AND HOUR OF DEATH 9/17/67 4:15 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21202 D. STREET ADDRESS (If rural, give location) 2075 E. HIGH ST. 209 S. High St.			
5. SEX M	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 1/4/15	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY BALT. CITY DEPT OF SEWAGE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME NICHOLAS BACCALA		14. MOTHER'S MAIDEN NAME MARIA Valentino		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES II		16. SOCIAL SECURITY NO. 215-01-1372		17. INFORMANT MEDICAL RECORD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO HODGKINS SARCOMA (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 10 1967 to Sept 17 1967, that (I) (we) last saw the deceased alive on Sept 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. W. Williams		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept 17, 1967	
23C. PHYSICIAN'S NAME (Type) MERAE W. Williams		23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21-67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery 5501 Frederick Rd. Balt. Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967			
25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Frank Della Noel		ADDRESS 322 S. High St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8968				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8968	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ISABELLA MOSES				2. DATE AND HOUR OF DEATH SEPT. 17, 1967 9:30 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1116 E. 20th St. 21218			
5. SEX F.	6. RACE N.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH 11-4-1904	9. AGE (In years last birthday) 42	10. Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) SO. CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Philip Thomas Gibson				14. MOTHER'S MAIDEN NAME Lovice Gibson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT Chart		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) AC. MYOCARDIAL INFARCTION				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that Dr. (this hospital) attended the deceased from 9/16/67 to 9-17-1967 that (I) Dr. last saw the deceased alive on 9/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (do not) view the body after death.							
23A. SIGNATURE Erin J. Smayda M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9/17/67			
23C. PHYSICIAN'S NAME (Type) PRINYA TIPMONGKOL				23D. ADDRESS M.D. NORTH CHARLES GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-21-67		24C. NAME OF CEMETERY or CREMATORY ARbutus Mem PK.		24D. LOCATION (City, town, or county) (State) Balt. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Morton + Dyett		ADDRESS 1701 LAURENS	

11-11-1911

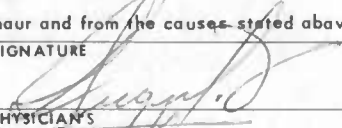
James Gibson

James Gibson

James Gibson
11-11-1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8969	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 8969 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LUCAS, James Edward			2. DATE AND HOUR OF DEATH 9/16/67 5:00 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 6. STREET ADDRESS (If rural, give location) 2657 HARLEM AVENUE		
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 10-1-19	9. AGE (In years last birthday) 47	10. Under 1 Yr. Months Days 16-06 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLY LINEMAN		10B. KIND OF BUSINESS OR INDUSTRY AUTO MANUFACTURES		11. BIRTHPLACE (State or foreign country) CURRITUCK COUNTY, N. C.	
13. FATHER'S NAME EDWARD LUCAS			14. MOTHER'S MAIDEN NAME RONA WALKER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 5-15-41 TO 7-16-45		16. SOCIAL SECURITY NO. 212-28-9325		17. INFORMANT HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD., BALTIMORE, MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 593X I UREMIA NEPHRITIS			CAUSE OF DEATH (A) UREMIA DUE TO (B) NEPHRITIS DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 10 September 19 67 to 16 September 19 67, that (X) (we) lost saw the deceased alive on 16 September 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 17 Sep 67	
23C. PHYSICIAN'S NAME (Type) ISHMAEL ANGULO		23D. ADDRESS V. A. HOSPITAL 3900 LOCH RAVEN BLVD., BALTIMORE, MARYLAND 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-21-67		24C. NAME OF CEMETERY or CREMATORY BALTO. NAT.	
24D. LOCATION (City, town, or county) (State) BALTO. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS MORTON to Dye II 1701 LAWRENS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 8970</u>	
BIRTH NO. <u>67 8970</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CLARENCE Campbell</u>		2. DATE AND HOUR OF DEATH <u>9-17-67</u> <u>7 30</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>16-01</u> D. STREET ADDRESS (If rural, give location) <u>1007 W. Lafayette Ave</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5-25-89</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Lynn</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Rebecca Campbell 1007 W. Lafayette</u>	
18. <u>443 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cerebrovascular hemorrhage</u> DUE TO (B) <u>Hypertensive Cardiovascular Disease</u> DUE TO (C) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>? years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pneumonia</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9/14</u> 19 <u>67</u> to <u>9/17</u> 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>9/17</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kenneth Stein</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/17/67</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-22-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Carver Mem</u>	
24D. LOCATION (City, town, or county) <u>Laurel</u>		(State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fagan</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTON & DYETT 1701 Laurens</u>	

1911

Robert Campbell 1901 W. 1st St.

1911 1st St. 1st St. 1st St.

1911 1st St. 1st St. 1st St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8971				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8971	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) JAMES, DOROTHY		2. DATE AND HOUR OF DEATH 9-16-67 1 25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 16-08			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Md. Inc. 46				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 29			
				D. STREET ADDRESS (If rural, give location) 3918 Glen Hunt Rd.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-9-34	9. AGE (In years last birthday) 32	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife home			10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Mulberry, Fla.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Taylor				14. MOTHER'S MAIDEN NAME Eliza Cromatic			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-30-9893		17. INFORMANT Louis E. James		ADDRESS 3918 Glen Hunt Rd.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410 X I (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH Pulmonary Embolism (suspected) + Hr. + (A) DUE TO Chronic Atrial Fibrillation - Many years (B) DUE TO Rheumatic Heart Disease - 5 years + (C) Mitral Valve Prosthesis		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 9-16 19 67 to 9-16 19 67, that (X) (we) last saw the deceased alive on 9-16 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-16-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. Lutheran Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-22-67		24C. NAME OF CEMETERY or CREMATORY Arbutus		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR MORTON + Dyett		ADDRESS 1701 LAURENS	

W. H. F. A.
Eliza G. G. G.

F. K. Taylor

General David A. C.

Proctor - J. H. G.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8972	
BIRTH NO. 67 8972		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BRISCOE LOUISE M. (BANKS)		2. DATE AND HOUR OF DEATH 9-15-67 5 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-02 D. STREET ADDRESS (If rural, give location) 5309 Fernpark Ave.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid.	8. DATE OF BIRTH 1-3-1903	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ST. MARYS Co., Md.	
13. FATHER'S NAME DANIEL GROSS		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mildred Battle 5309 Fernpark.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C. V. A.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Anteriosclerotic Cardiovascular disease Rheumia		INTERVAL BETWEEN ONSET AND DEATH 9 months	
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-10-1967 to 9-15-1967 , that (I) (we) last saw the deceased alive on 9-15-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-15-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI		23D. ADDRESS Lutheran Hospital of Maryland, 730 Ashburton St. Baltimore, Md. 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-19-67		24C. NAME OF CEMETERY or CREMATORY Arbutus MemPk.	
24D. LOCATION Arbutus Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE RECEIVED BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR ADDRESS MORTON J. DYETT 1701 HAYMARKS	

St. Mary's Co. Md. 1824
Mary Ellen Cross
Mary Battle 2305 Kentucky

Unemployed
Daniel Cross
No

Burgess 411-11 Debitors Mary 1824
Md
1824

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY PETERSON

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1967 12:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

706 Dolphin St.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

5/16/1914

9. AGE (In years
last birthday)

53

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George H. W. Jackson

14. MOTHER'S MAIDEN NAME

Mary L. Nolan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-18-9768

17. INFORMANT

Mary Ethel Smith

ADDRESS

706 Dolphin

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

September 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-21-67

23C. NAME OF CEMETERY or CREMATORY

BALTO. NAT.

23D. LOCATION

BALTO.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

MORTON + Dyett

ADDRESS

1701 LAURENS

67-100-100-100

no

George H. Jackson

Mary I. Nolan

Baldwin, Md.

William

and Mrs. Jackson 24

MD

Baldwin

and

Baldwin

and

Baldwin

London - 100-100-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8974				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8974	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) KENNEDY, SAM NMI				2. DATE AND HOUR OF DEATH 9/14/67 1:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3024 Belmont Ave.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/4/22	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTHPLACE (State or foreign country) WINSBORO, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SAM KENNEDY				14. MOTHER'S MAIDEN NAME EMMA SANDERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 7/15/43 to 6/17/46				16. SOCIAL SECURITY NO. 216 28 66 39		17. INFORMANT ADDRESS VA Hospital Records VA Hospital, Baltimore, Maryland 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY TUBERCULOSIS TREATED (probably inactive) ASPERGILLOSIS LEFT UPPER LOBE LUNG				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Since 1942 For Years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. COR PULMONALE ACUTE HEMOPTYSIS						For Months For Days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from September 12 1967 to September 14 1967 , that (2) (we) last saw the deceased alive on September 14 1967 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.							
23A. SIGNATURE Zaheer ud Din M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 9/14/67	
23C. PHYSICIAN'S NAME (Type) ZAHKEER-UD-DIN, M. D.				23D. ADDRESS VA Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-20-67		24C. NAME of CEMETERY or CREMATORY BALTO. NAT'L.		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Robinson		25C. FUNERAL DIRECTOR MORTON J. DYETT		ADDRESS 1701 LAURENS ST.	

SEP 19 1967

Notes on the

2nd Ball Race

MA

B-653

67 8975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 8975

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

THOMAS BRANDON

2. DATE AND HOUR OF DEATH

15 Sept 1967 11245 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

BALTIMORE CITY HOSPITALS

31 4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Turners Station

D. STREET ADDRESS (If rural, give location)

111 WALNUT AVENUE 21222

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

1-5-89

9. AGE (In years
lost high day)

78

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Shipyard

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINE

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

SYDNEY

14. MOTHER'S MAIDEN NAME

CLARISSA

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-09-7879

17. INFORMANT

BCH: RECORDS 4940 EASTERN AVENUE 21224

ADDRESS

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Respiratory Insufficiency

INTERVAL BETWEEN
ONSET AND DEATH

26 yrs.

(B) DUE TO

old surgical procedure thorax

26 yrs.

(C) DUE TO

Traumatic injury

26 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.Renal insufficiency
History of recurrent GI bleeds.

19A. DATE OF OPERATION

21

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 5 19 67 to Sept 15 19 67, that (I) (we) last saw the deceased alive on Sept 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joel Thurm

M.D.

Attending Phys.

Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

9/15/67

23C. PHYSICIAN'S NAME (Type)

DR. JOEL THURM

M.D.

23D. ADDRESS

4940 EASTERN AVENUE BALTO. MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

9-20-67

24C. NAME OF CEMETERY OR CREMATORY

MT. CALVARY

24D. LOCATION (City, town, or county) (State)

A. A. Co.,

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

MORTON & Dyer

ADDRESS

1701 LAURENS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Shirley
Bobbie Steel

2-2-55

From the [unclear]

to the [unclear]

to the [unclear]

to the [unclear]

to the [unclear]

to the [unclear]

to the [unclear]

to the [unclear]

Printed by MT. Columbia
H. A. Co.

Printed by MT. Columbia
H. A. Co.

1
G-435

67 8976 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8976

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HILDA GOLDMAN

2. DATE AND HOUR PRONOUNCED DEAD

September 13, 1967 12:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1830 Ashland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1830 Ashland Ave.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 1897

9. AGE (in years last birthday)

70

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

va

12. CITIZEN OF WHAT COUNTRY?

usa

13. FATHER'S NAME

Elias Boyd

14. MOTHER'S MAIDEN NAME

Georgia White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213.36.0587

17. INFORMANT

Family

ADDRESS

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/16/67

23C. NAME OF CEMETERY or CREMATORY

West Calvary Cemetery A.A.B. Vol

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Robert Williams 171-3110

ADDRESS

VALLEY FORD

March 1881
Thomas Boyd
James Boyd
John Boyd
William Boyd
George Boyd
Charles Boyd
Henry Boyd
Robert Boyd
Richard Boyd
Edward Boyd
Francis Boyd
Thomas Boyd
James Boyd
John Boyd
William Boyd
George Boyd
Charles Boyd
Henry Boyd
Robert Boyd
Richard Boyd
Edward Boyd
Francis Boyd

April 17 1881
John Boyd
James Boyd
Thomas Boyd
William Boyd
George Boyd
Charles Boyd
Henry Boyd
Robert Boyd
Richard Boyd
Edward Boyd
Francis Boyd
John Boyd
James Boyd
Thomas Boyd
William Boyd
George Boyd
Charles Boyd
Henry Boyd
Robert Boyd
Richard Boyd
Edward Boyd
Francis Boyd

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-600		67 8977		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8977	
1. NAME OF DECEASED (Type or Print) JAMES D. PERRY				2. DATE AND HOUR OF DEATH SEPTEMBER 18, 1967 3:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE UNION MEMORIAL HOSPITAL 332 + CALVERT STREETS BALTIMORE, MARYLAND 21218				4. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-01 D. STREET ADDRESS (If rural, give location) (Formerly) 3606 PARKSIDE DRIVE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-11-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) TENNESSEE		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME J. Edward Perry				
14. MOTHER'S MAIDEN NAME Tempie Carrier			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 44-09-737			17. INFORMANT Mr. William S. Perry (son)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD w/ Acute Myocardial Infarction			19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Aspiration pneumonia			20. INTERVAL BETWEEN ONSET AND DEATH 4827 BOWLAND AVE BALTIMORE MD 21206	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. M. C. pneumonia w/d.				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from August 30, 1967 to SEPTEMBER 18, 1967 , that (we) last saw the deceased alive on SEPTEMBER 18, 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.							
23A. SIGNATURE William H. Spencer-Strong M.D.				23B. DATE SIGNED September 18, 1967		23C. PHYSICIAN'S NAME (Type) WILLIAM H. SPENCER-STRONG M.D.	
23D. ADDRESS THE UNION MEMORIAL HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/67		24C. NAME OF CEMETERY or CREMATORY Gdns. of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REGD. BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd			

Page 4 Perry

September 13 3:10 PM

WASHING

BATHING

THE UNION MEDICAL HOSPITAL

217 + CALVERT STREET

3602 PARKSIDE DRIVE

BALTIMORE, MARYLAND 21218

11-1-01 62

MALE CARRAN WIDOWED

TENNESSEE

U.S.A.

Perry (First Name) UNKNOWN

9573 BOWLING

MY-09-333M. William C. Perry (son) Baltimore, MD

4500 W. of Route

Highland Avenue

Aspirin treatment

Ch of Surgery

YES

August 30

SEPTEMBER 13 62

September 13 62

William H. Jones - 2nd

X

September 13 1962

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-26-2010 BY SP-6 BJS/STP

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

(J.)

LAWRENCE GOELLER

2. DATE AND HOUR PRONOUNCED DEAD

September 18, 1967 1:09 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

328 Tmla Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/14/1911

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months, Oays Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Machinist

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Constantine Goeller

14. MOTHER'S MAIDEN NAME

Margaret Koehler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

216034357

17. INFORMANT

ADDRESS

Mrs. Katherine E. Goeller - Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Oay) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/22/67

23C. NAME of CEMETERY or CREMATORY

Sacred Heart Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. 5305 Harford Rd.

ADDRESS

WALLER PAPER
LONDON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8979	
BIRTH NO. 67 8979		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Carl Fossey Johns		2. DATE AND HOUR OF DEATH 9-18-67 1:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balt. City		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hosp		D. STREET ADDRESS (If rural, give location) 396 E. 31st St.		12-02	
5. SEX M	6. RACE W	7. <u>MARRIED</u> , NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11/13/96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Mechanic		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carl Johns		14. MOTHER'S MAIDEN NAME Annie ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. XXXXXX XXXXX		17. INFORMANT Mrs. Anna Johns - Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 422.1 (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Acute Confluent Bronchopneumonia AS CVD		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Plum & Throat R			
(C) MC Jensen & Wd.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 9/10 19 67 to 9/18 19 67 , that (I) <u>(we)</u> last saw the deceased alive on 9/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE Barry J. Weckesser				23B. DATE SIGNED 9/18/67	
23C. PHYSICIAN'S NAME (Type) BARRY J. WECKESSER				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.			
25D. ADDRESS 5305 Harford Rd.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8980		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8980	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA SPINELLA		2. DATE AND HOUR OF DEATH 9/16/67 3¹⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 3208 OLD NORTH POINT RD.			
5. SEX F	6. RACE W	7. (MARRIED) NEVER MARRIED WIDOWED , DIVORCED (specify)		8. DATE OF BIRTH 12/27/06	9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAVATORE DEPIETRO		14. MOTHER'S MAIDEN NAME ROSALIE MICELI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 099 03 7758		17. INFORMANT PATIENT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 199.21		CAUSE OF DEATH (A) GENERALIZED CARCINOMATOSIS DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard H. Barol		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/16/67	
23C. PHYSICIAN'S NAME (Type) Richard H. Barol		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/20/67		24C. NAME of CEMETERY or CREMATORY St. John's Cemetery	
24D. LOCATION (City, town, or county) (State) Middle Village, Queens, N. Y.					
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.	
ADDRESS 1217 St. Paul St.					

[Handwritten signature]

Richard H. Bury

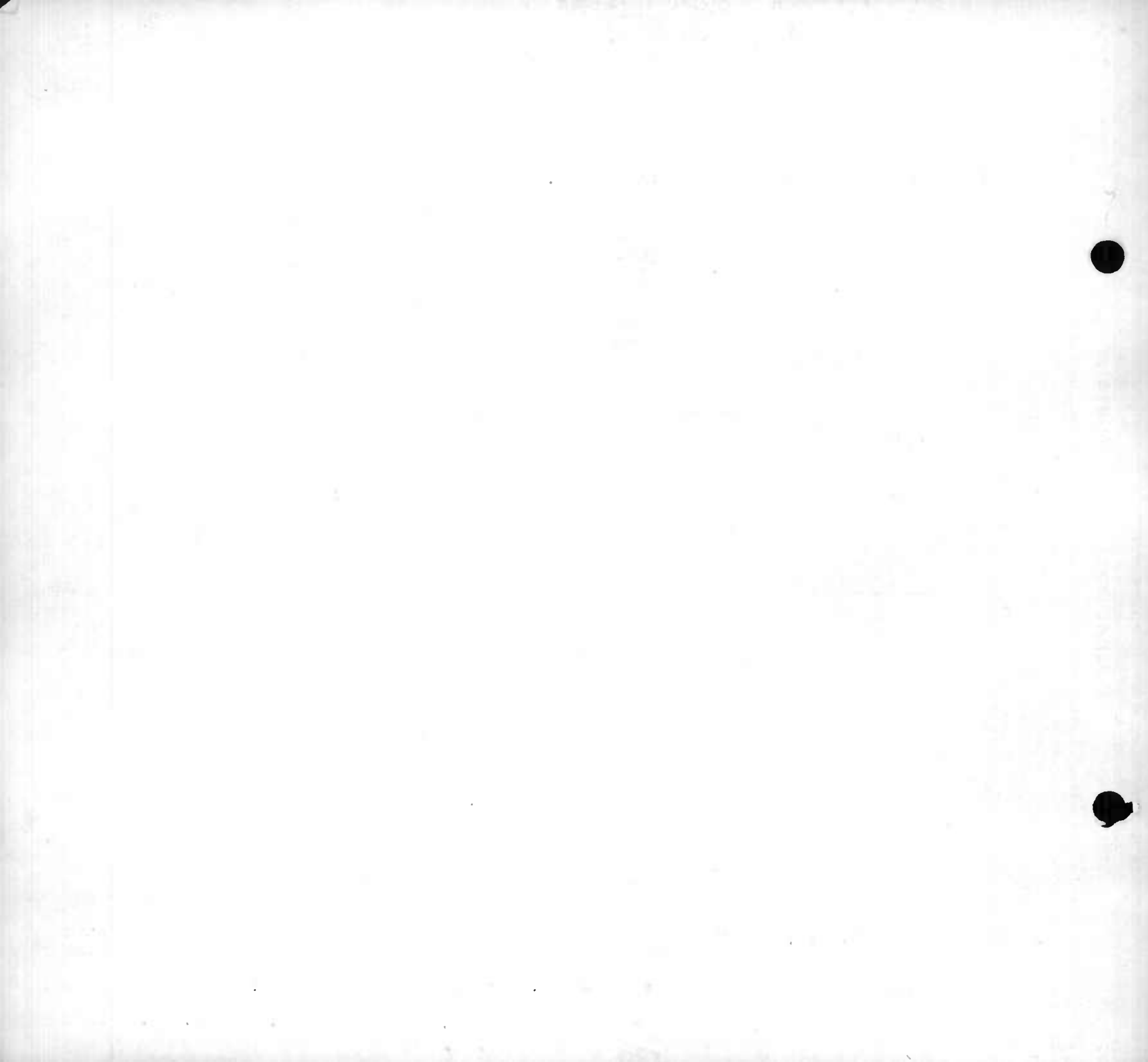
Marshall County, Maryland

4/1/61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 928 8981	
BIRTH NO. 67 8981		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SHIVES, ANNA		2. DATE AND HOUR OF DEATH 9/15/67 4:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Convelesant & Nursing Ctr.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1436 John Street			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/1/82	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Wenhoff		14. MOTHER'S MAIDEN NAME Barbara Boehnlein			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral hypoxia with retactions to brain (B) with (C) retactions to brain ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1/67 to 9/15 19 67 . that (I) (we) last saw the deceased alive on 9/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. E. Cook		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/16/67	
23C. PHYSICIAN'S NAME (Type) Dr. E. Cook		23D. ADDRESS 2 E READ ST 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/67		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Ann Arundel County, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Balto. Md. 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8982				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8982			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				M.			
BARBARA J. MUELLER				8:10AM 9/15/67							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL				SOUTH DAKOTA							
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				CHAMBERLAIN				V-38			
				D. STREET ADDRESS (If rural, give location)							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days	
FEMALE		WHITE		NEVER MARRIED		11-10-44		22			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
								12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
HENRY MUELLER				HAZEL JONES CLET							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
18. 754.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
				(A) Pulmonary insufficiency				7 days			
				(B) Tetralogy of Fallot							
				(C)							
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
9/6/67		Tetralogy of Fallot		Yes		No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
No		No		No							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 9/3/67 to 9/15 1967, that (I) (we) last saw the deceased alive on 9/15 1967 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Hewes D. Agnew				9/15/67							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Hewes D. Agnew				Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		9/15/67		Riverview cemetery		Chamberlain, South Dakota					
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
SEP 19 1967		Robert E. Taylor, M.D.		Wm. Cook-Brooks Inc. Balto. Md. 21202							

James M. Smith
1847

James M. Smith
1847

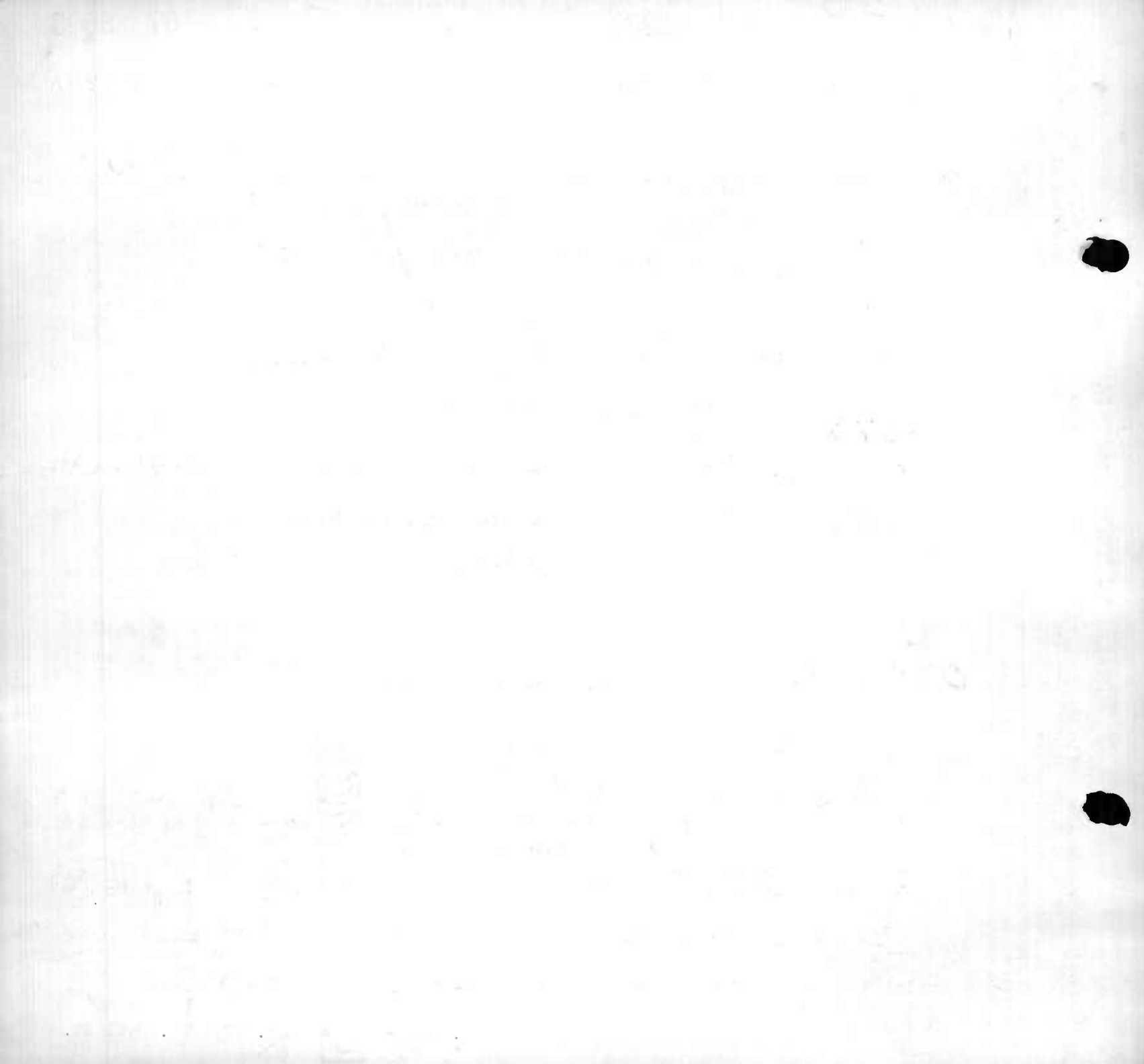
—

James M. Smith
1847

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 17-120		67 8983		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8983	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Roland R. Davis				2. DATE AND HOUR OF DEATH 9-16-67 12:18 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US PHS Hosp., Baltimore, Md				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Fla. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ft. Lauderdale V-08 D. STREET ADDRESS (If rural, give location) 3841 S.W. 11st			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-2-15	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USCG Ret.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Henry Davis			14. MOTHER'S MAIDEN NAME Cecil Owens				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1937 to 1964		16. SOCIAL SECURITY NO. 082-09-210		17. INFORMANT Chart			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH 4+ months ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) liver failure DUE TO (B) Liver metastases DUE TO (C) adenocarcinoma of stomach			
19A. DATE OF OPERATION Sept 15, 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal mass		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from July 18 1967 to Sep 16 1967, that (we) last saw the deceased alive on Sep 16 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.							
23A. SIGNATURE D S Alberts				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sep 16, '67	
23C. PHYSICIAN'S NAME (Type) David S. Alberts		23D. ADDRESS M.D. US PHS Hospital, Baltimore, Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/67		24C. NAME of CEMETERY or CREMATORY Arlington National Cemetery		24D. LOCATION (City, town, or county) (State) Arlington, Virginia	
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD J. LaBrier XXXX

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1967 5:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF
 HOSPITAL OR
 INSTITUTION
 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
 ADDRESS OR LOCATION)
 00 2828 N. Calvert St. (DOA)
 9-27-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2828 N. Calvert St.

5. SEX

Male

6. RACE

White

7. MARRIED-NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

12/15/09

9. AGE (In years
last birthday)

57 XXX

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PAINTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

TENN.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George LaBrier

14. MOTHER'S MAIDEN NAME

Mary Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Floyd Turnage, Memphis, Tenn.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

--No-- Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☒ and that on this basis, death in my opinion
 resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

9/17/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/20/67

23C. NAME of CEMETERY or CREMATORY

CALVERY CEMETERY

23D. LOCATION

(City, town, or county)

(State)

MEPHIS, TENN.

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

HOWARD H. HUBBARD

ADDRESS

4107 WILKENS AVE. 21229

Letter from Medical Examiner's Office
9-27-67 M.H.

BIRTH NO.		M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
D-362		67 8985		BALTIMORE CITY HEALTH DEPARTMENT		67 8985	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
FRED L. Dieterick DIETERICK				September 17, 1967 2:15 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
St. Agnes Hospital (DOA)				Maryland Baltimore			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. AGE (In years last birthday)			
Male White Married				2-3-1907 60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Engineer				Maryland			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Westinghouse				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lawrence C. Dieterick				Priscilla Wisner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				088-09-0324			
17. INFORMANT				ADDRESS			
Mrs. Ella E. Dieterick, 1222 Elmridge Ave.				21229			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Carbon Monoxide Poisoning			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
19A. DATE OF OPERATION				No			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				Driveway			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
1222 Elmridge Avenue				9/17/67 UNK			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Connected hose to exhaust of car and placed it in trunk. (Motor running)			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/>				and that on this basis, death in my opinion			
resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Werner U. Spitz, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)				23B. DATE			
Burial				9-20-1967			
23C. NAME OF CEMETERY or CREMATORY				23D. LOCATION (City, town, or county) (State)			
Loudon Park Cemetery				Baltimore, Maryland			
24A. DATE REC'D BY HEALTH DEPT.				24B. NAME OF REGISTRAR			
SEP 19 1967				Robert E. Taylor			
24C. FUNERAL DIRECTOR				ADDRESS			
Howard H. Hubbard, 4107 Wilkens Ave.				21229			

1. [illegible] [illegible] [illegible]

2. [illegible] [illegible] [illegible]

3. [illegible] [illegible] [illegible]

4. [illegible] [illegible] [illegible]

5. [illegible] [illegible] [illegible]

6. [illegible] [illegible] [illegible]

7. [illegible] [illegible] [illegible]

8. [illegible] [illegible] [illegible]

9. [illegible] [illegible] [illegible]

10. [illegible] [illegible] [illegible]

11. [illegible] [illegible] [illegible]

12. [illegible] [illegible] [illegible]

13. [illegible] [illegible] [illegible]

14. [illegible] [illegible] [illegible]

15. [illegible] [illegible] [illegible]

16. [illegible] [illegible] [illegible]

17. [illegible] [illegible] [illegible]

18. [illegible] [illegible] [illegible]

19. [illegible] [illegible] [illegible]

20. [illegible] [illegible] [illegible]

21. [illegible] [illegible] [illegible]

22. [illegible] [illegible] [illegible]

23. [illegible] [illegible] [illegible]

M-625

67 8986

BALTIMORE CITY HEALTH DEPARTMENT

67 8986

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH S. MORRISON

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1967 4:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3810 Benson Avenue 21227

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3810 Benson Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7-27-1912

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerical

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Morrison

14. MOTHER'S MAIDEN NAME

Martha Slawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

216-03-1626

17. INFORMANT

ADDRESS

Mrs. Margaret F. Morrison, 3810 Benson Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/21/67

23C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1967

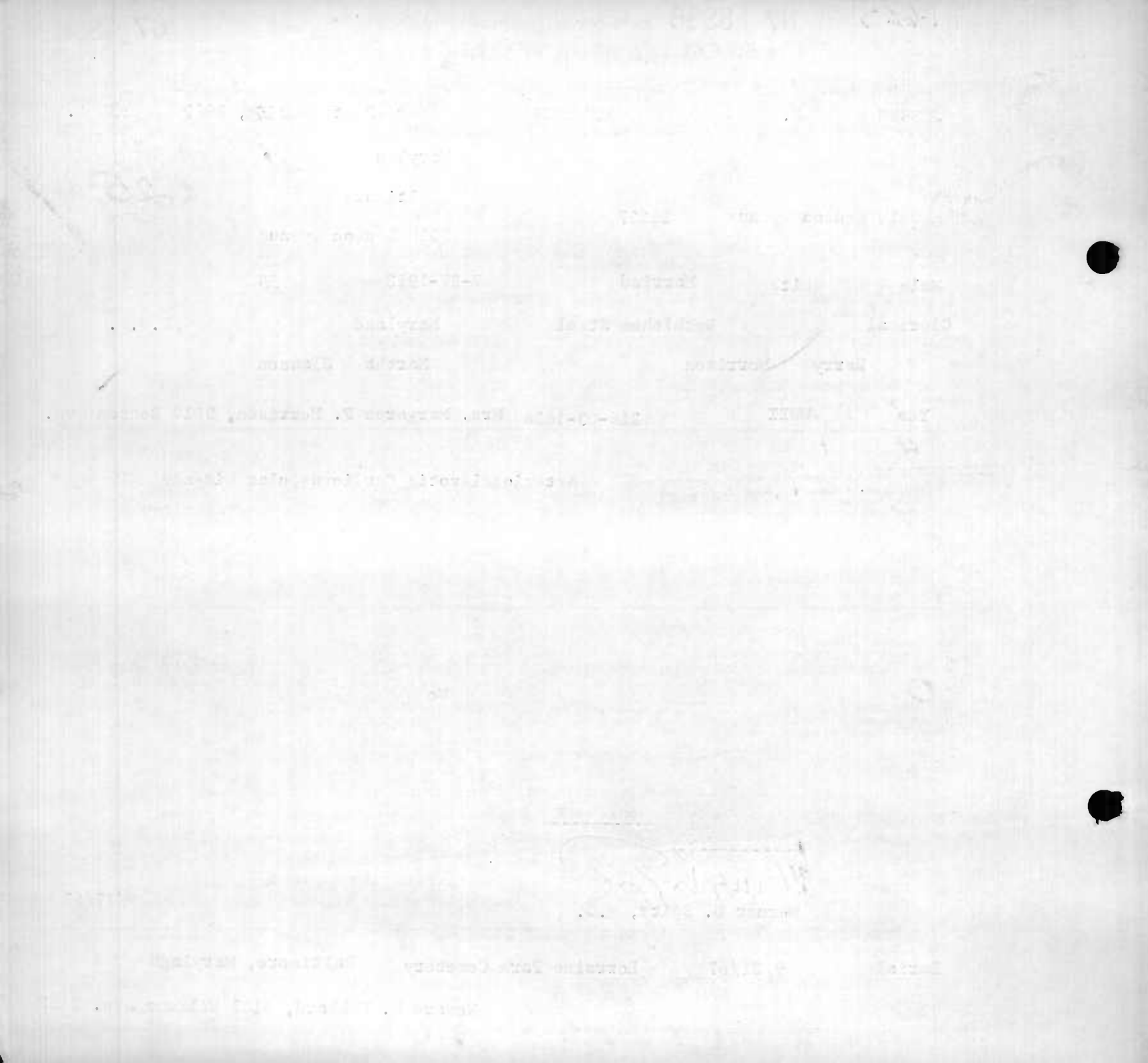
24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-425 BIRTH NO. <i>Talbot Co, Md.</i>		67 8987		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <i>X</i> 67 8987	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Kevin</i> DOUGLAS MILLIGAN				2. DATE AND HOUR OF DEATH 9-15-67 9:20 AM M.			
3. PLACE OF DEATH <i>IN</i> BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Dorchester</i>			
FULL NAME OF HOSPITAL OR INSTITUTION 3 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Rhodesdale, Md</i>			
				D. STREET ADDRESS (If rural, give location) <i>59-00</i>			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 7-2-63	9. AGE (In years last birthday) 4	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME DAVIS L. MILLIGAN				14. MOTHER'S MAIDEN NAME JOAN C. BOLLINGER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>M Davis L Milligan</i> <i>Rhodesdale, Md</i>		ADDRESS	
18. <i>204.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>ASPIRATION OF BLOOD</i> DUE TO (B) <i>LEUKEMIA</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not White Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-1-67</i> 19 to <i>9-15-67</i> 19 that (I) (we) last saw the deceased alive on <i>9-15-67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Joerg C. Winterer</i>						23B. DATE SIGNED 9-15-67	
23C. PHYSICIAN'S NAME (Type) JOERG C. WINTERER				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sept 17-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Methodist</i>		24D. LOCATION (City, town, or county) (State) <i>Brookview, Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 19 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jones</i>		25C. FUNERAL DIRECTOR <i>Harry E. Warby</i>		ADDRESS <i>Seaford, Del</i>	

100

100

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-200		67 8988		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8988	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Mrs. Dash Catherine		9/18/67 5:15 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
35 Church Home & Hospital				Md. Balto.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Balto. 6-02			
				D. STREET ADDRESS (If rural, give location)			
				2504 E. Fairmont Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
F.	W.	Married	12/16/83	83			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		-		Balto. Md.		Balto.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Mr. Henry Pinecker				Mrs. Anna Depkin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
unknown				2/5-01-60950		-	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Bleeding Duodenal Ulcer				(A) DUE TO		4 days	
Malignancy, Organ?				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
9-17-67		Bleeding Peptic Ulcer					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9-15 1967 to 9-18 1967, that (I) (we) last saw the deceased alive on 9-18-67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Joseph Ortiz						9-18-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/22/67		Sacred Heart Of Jesus Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 19 1967		Robert E. Faldut		John A. Moran, Inc.		3000 E. Baltimore St.	

(1st) 100 100

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100 100 100 100

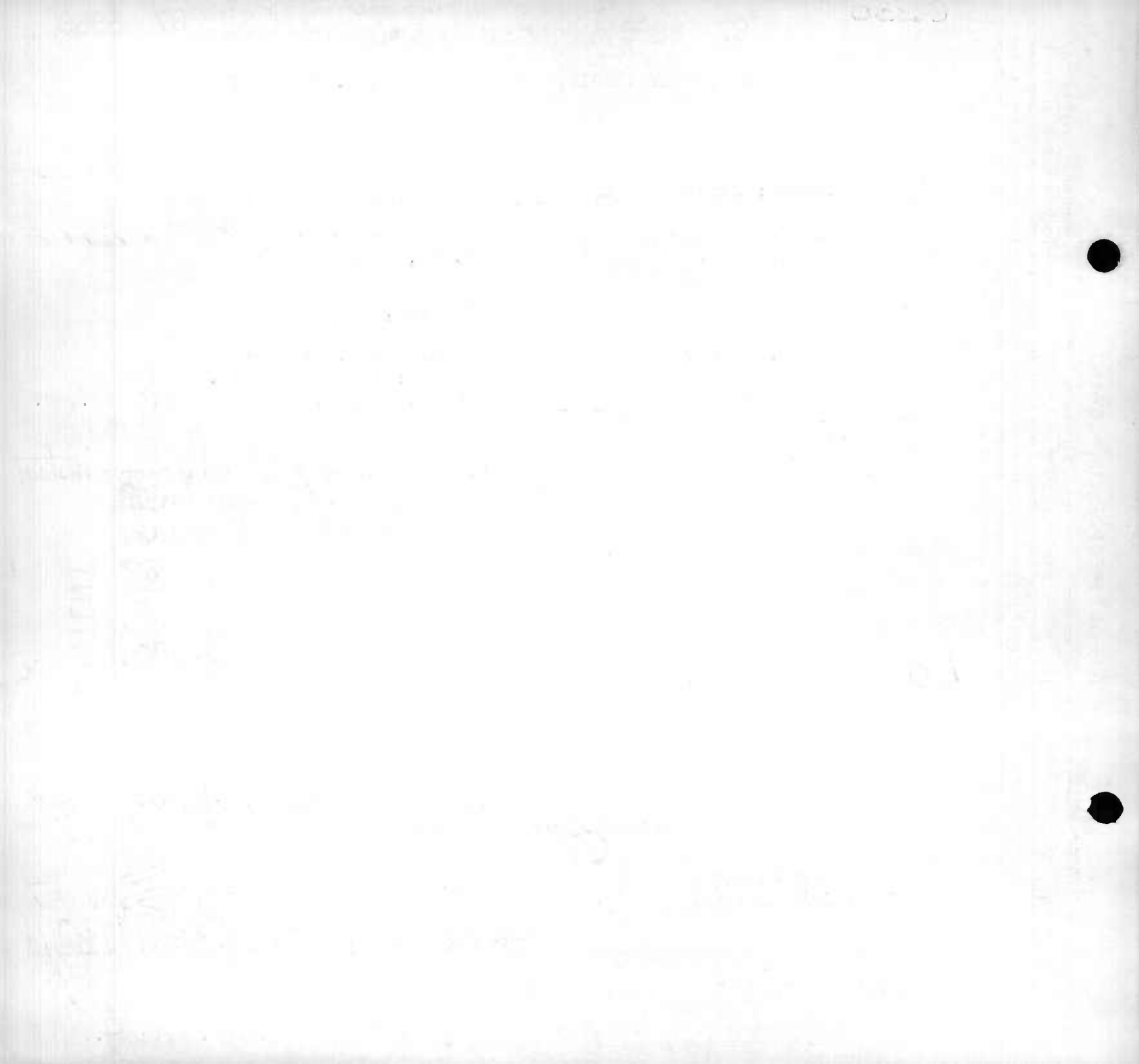
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-230		67 8989		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8989	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MILDRED STEWART CASSIDY				Sept. 16, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE			
(If not in hospital or institution, give street address or location)				B. COUNTY			
00 Residence: Severn Apartments - - 701 Cathedral				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				City of Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				701 Cathedral Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
Female	White	Never married	Feb. 15, 1894	73 years			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
NONE		NONE		Baltimore, Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank B. Cassidy				Estelle I. Stewart			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT: sister of Dec'd.		ADDRESS	
NO		220-44-3552		Elise S. Cassidy, 701 Cathedral, Balto., Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Acute Coronary Occlusion - instant			
ANTECEDENT CAUSES		(B) DUE TO		Hypertensive Atherosclerotic			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		Cardiovascular disease			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9 Dec. 1946 to 16 Sept. 1967, that (I) (we) lost saw the deceased alive on 16 Sept. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Joseph E. Muse Jr.				18 Sept. '67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D. 2725 N. Charles St. Balto. 18 Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/20/67		Cathedral Cemetery		Baltimore, Maryland	
25A. DATE RECD. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 19 1967		Robert E. Taylor		STEWART & MOORE CO. 108 W. North Av., City 1			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
G-655 67 8990					CERTIFICATE OF DEATH					Registered No. 67 8990						
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH											
Sister Anne Gorman					September 16, 1967					1:15 P.M. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa Saint Michael Baltimore, Maryland 21207					A. STATE Maryland					B. COUNTY Baltimore City 21207						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 4000 Forest Hill Road,						
5. SEX F.		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married		8. DATE OF BIRTH 1875 April 5, 1876		9. AGE (In years last birthday) 91 92		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - nurse					10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity					11. BIRTHPLACE (State or foreign country) Shelderales, Minnesota					12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME David Gorman					14. MOTHER'S MAIDEN NAME Johanna Kennedy											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 220-48-5047		17. INFORMANT Sister Andrea					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 199.2 I					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost.					(A) DUE TO Cancer of bladder and uterus					18 months						
					(B) DUE TO											
					(C) Cardio-vascular					several days						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION None			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?										
22. I certify that (I) (this hospital) attended the deceased from April 19 52 to September 12, 19 67 and that (I) (we) lost saw the deceased alive on September 12, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE Dorothy Pelagia					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED						
23C. PHYSICIAN'S NAME (Type) Bar					23D. ADDRESS 3326 Indsuck Rd. Baltimore, Md.											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9/19/67		24C. NAME of CEMETERY or CREMATORY Seton Cem. (on property of Seton Inst., Reisterstown Rd.)			24D. LOCATION (City, town, or county) (State) Baltimore, Md.								
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1967			25B. NAME OF REGISTRAR Robert G. Taylor			25C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av. City			ADDRESS							

1. The first part of the report

concerns the general situation

2. The second part of the report

concerns the specific details

3. The third part of the report

4. The fourth part of the report

concerns the future prospects

5. The fifth part of the report

concerns the conclusions

6. The sixth part of the report

concerns the recommendations

7. The seventh part of the report

concerns the summary

8. The eighth part of the report

concerns the appendix

9. The ninth part of the report

concerns the bibliography

10. The tenth part of the report

concerns the index

11. The eleventh part of the report

concerns the cover

12. The twelfth part of the report

concerns the title page

13. The thirteenth part of the report

concerns the foreword

14. The fourteenth part of the report

concerns the acknowledgments

15. The fifteenth part of the report

concerns the list of figures

16. The sixteenth part of the report

concerns the list of tables

17. The seventeenth part of the report

concerns the list of references

1
B-516

67 8991 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8991

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MELVIN BUMBRAY

2. DATE AND HOUR PRONOUNCED DEAD

September 15, 1967 1:21 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2133 McCulloh St. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2133 McCulloh St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 1, 1908

9. AGE (in years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Alfred Bumbrey

14. MOTHER'S MAIDEN NAME

Hallie Fletcher

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Son

ADDRESS

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 15, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-20-67

23C. NAME of CEMETERY or CREMATORY

Balto. Nat'l Cem.

23D. LOCATION

Balto.

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Sullivan Funeral Home - 1011-13 N. Arlington Ave

ADDRESS

Handwritten text, likely a letter or document, with some legible words such as "Dear", "I", "am", "writing", "to", "you", "today".

Handwritten text, likely a letter or document, with some legible words such as "I", "am", "writing", "to", "you", "today".

Handwritten text, likely a letter or document, with some legible words such as "I", "am", "writing", "to", "you", "today".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-625 BIRTH NO. 67 8992		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 8992	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William A. Derschinger		2. DATE AND HOUR OF DEATH 7:45pm 9/17/67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) A.A. Co. 52-00 Hanover, Maryland	
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 1-11-25		9. AGE (In years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shiprunner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY United States of America		13. FATHER'S NAME Henry Paul Derschinger	
14. MOTHER'S MAIDEN NAME Dolly Jones		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 218-18-7491	
17. INFORMANT Belerma E. Derschinger - same		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 Thrombosis of Left Coronary Artery		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease		20. DUE TO		2 years	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
22. I certify that (X) (this hospital) attended the deceased from 9/17/67 to 9/17/67, that (X) (we) last saw the deceased alive on 9/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angel S. Gonzalez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/17/67	
23C. PHYSICIAN'S NAME (Type) ANGEL S. GONZALEZ		23D. ADDRESS Bon Secours Hosp - Balt - Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-20-1967		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A. A. Co., Md.					
25A. DATE RECEIVED BY HEALTH DEPT. SEP 20 1967		25B. NAME OF REGISTRAR Robert E. Fashina		25C. FUNERAL DIRECTOR George J. Gonca	
ADDRESS -4001 Ritchie Hgwy, Balto.					

Mr. J. H. H. H. H. H.
Rt. 2 Box 241 Forest Ave.
1-11-42
Machland
America

1200 Securus Hospital

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 8993

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE WARD

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1967 12:10 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home and Hospital

D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2542 Fait Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10-6-1908

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Villa Gardens

11. BIRTHPLACE (State or foreign country)

Westminster, Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W 11

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Raymond L. Ward 2542 Fait Avenue 21221

18.

E900.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2542 Fait Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9 17 67 11:45 a

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Subject fell down steps at home

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-20-1967

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1967

Robert E. Jackson

Laseahn Funeral Home 7401 Belair Rd

1912

1912

1912

1912

WALLACE WOODRIDGE

WALLACE WOODRIDGE

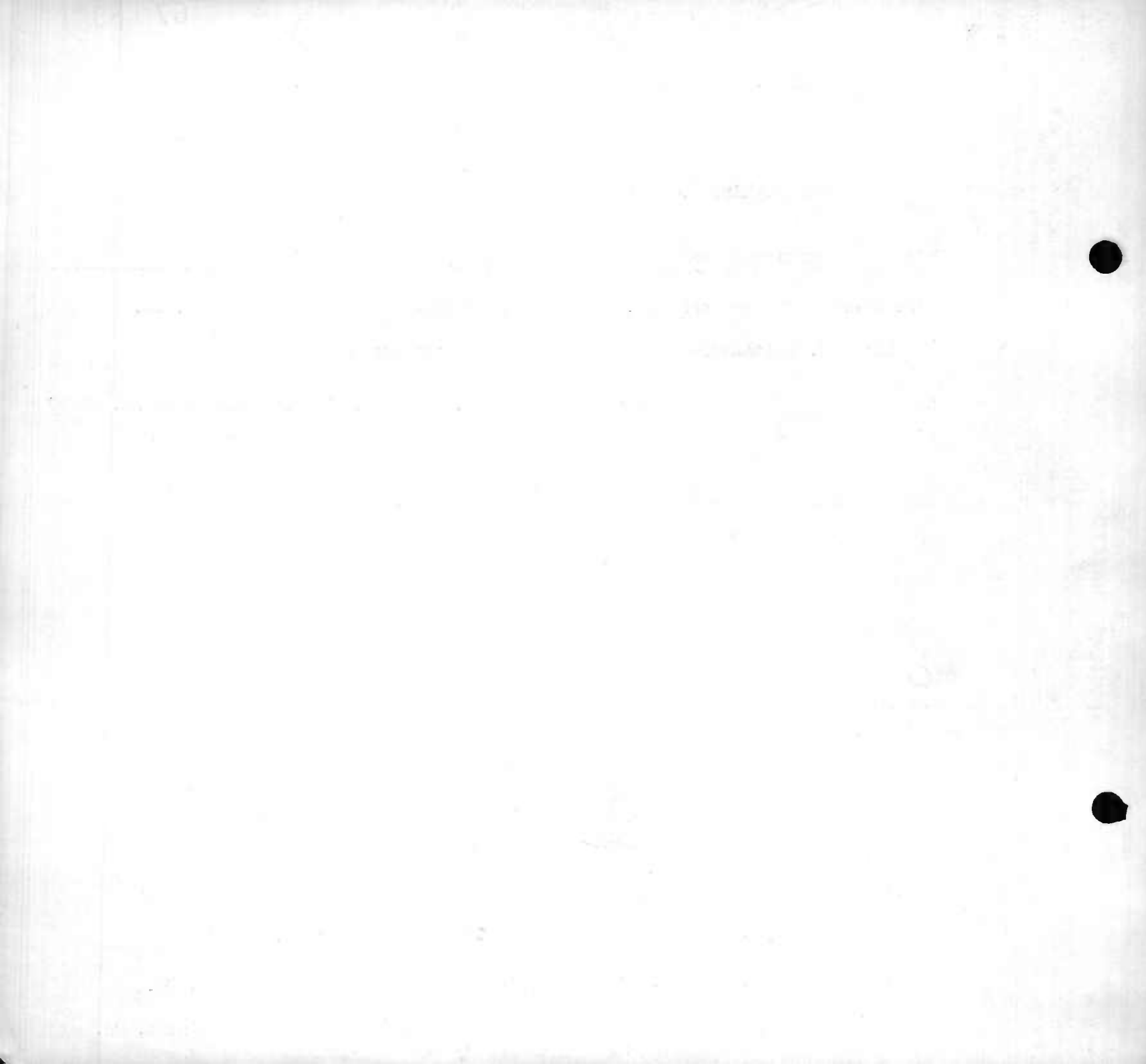
1912

1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8994				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8994	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HARRY O. WHITTEMORE		14 Sept. 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital				A. STATE Md. B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rosedale 53-00			
				D. STREET ADDRESS (If rural, give location) 1215 62nd St. #06			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Male	Caucasian	married	6 May 1904	63			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
time clerk			can mfr.		Maryland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Harry O. Whittemore				Sara Humes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no			215-09-6322		Mrs. Helen Whittemore, 1215 62nd St. 21237		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
420.1 I				Acute Coronary Occlusion			
ANTECEDENT CAUSES				Coronary Artery Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1966 to Sept 1967, that (I) (we) last saw the deceased alive on Sept 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
John G. Orth						9/15/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
John G. Orth,				M.D. 8019 Philadelphia Rd. 21237			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		9-18-67		Moreland Memorial Park		Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 20 1967		Robert E. Fickel		Ullrich		Funeral Home, Baltimore, Md.	



1
M-615

67 8995 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 8995

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE

E.

MARBURGER

2. DATE AND HOUR PRONOUNCED DEAD

September 15, 1967 8:00 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Pennsylvania

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ivyland

D. STREET ADDRESS (If rural, give location)

Box 178 A-Road 3 Traymore Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Feb 6 1931

9. AGE (in years lost birthday)

36

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Photographer

11. BIRTHPLACE (State or foreign country)

Phila Pa,

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Geo Marburger

14. MOTHER'S MAIDEN NAME

Clara Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; if yes, give war or dates of service)

16. SOCIAL SECURITY NO.

202 22 2082

17. INFORMANT

Dolores Marburger 3 Traymore Road

ADDRESS

18.

E816.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

620 ft. Middle River Road - Essex, Md. of Clover Avenue

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 9/15/67 7:19 P.

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR? Subj. operator of car - involved in head-on collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

Sept 19/67

23C. NAME of CEMETERY or CREMATORY

Whitemarsh Mem Park

23D. LOCATION

(City, town, or county)

Prospectville Pa,

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Ullrich Funeral Home 4210 Belair Road

ADDRESS

11869.2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 8936		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8936	
M.E. CASE NO.		1. NAME OF DECEASED AKA WILLIAM THOMAS CRAWFORD		2. DATE AND HOUR OF DEATH September 13, 1967 8:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
THE UNION MEMORIAL HOSPITAL 3320 + CALVERT ST. BALTIMORE, MARYLAND 21218		MARYLAND		BALTIMORE 4356 NICHOLAS AVENUE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
MALE	CAUCASIAN	MARRIED	11-11-87	79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
CLERK - RETIRED		BETHLEHAM STEEL CO.		MARYLAND U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William Thomas Crawford		ELIZABETH DIAMOND			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-07-4124		MRS. MARGARET CRAWFORD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) MYOCARDIAL INFARCTION			
ANTECEDENT CAUSES		(B) CORONARY THROMBOSIS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ATHEROSCLEROSIS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Benign Prostatic Hypertrophy, HCUA, Emphysema			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from September 7, 1967 to September 12, 1967, that (I) last saw the deceased alive on September 12, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
William H. Spencer-Strong				September 13, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
William H. Spencer-Strong		Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	Sept 20/67	Moreland Mem		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
SEP 20 1967	Robert J. Johnson	Upham Funeral Home		4210 Belair	

Wahlkreis H. Jansen - Steyer



2017-2018

8-10-1967

no
Berg, Kristin; Berg, Kristin

Prof. Robert H. Thompson

2.4. 0.950209-3H7H

21202 FRONT AVENUE S

APPROXIMATELY 1000

CH

2017-01-01 10:00 AM

William Thomas Crawford

ERISA ABETH DIVISION

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PC 58-11-11

DATE: 11/15/18

4026 Nicholas Avenue

33-404-1-1051 742

THE UNION MEMORIAL HOTEL, 24 HAYDORE

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 8997	
BIRTH NO. C-534		67 8997		CERTIFICATE OF DEATH	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HELEN M. CANTWELL			2. DATE AND HOUR OF DEATH Sep. 18, 1967 5:55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOUR HOSPITAL 34			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 5 RIDGE RD. 21228		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9/27/91	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED. ??		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME OWEN J. CANTWELL			14. MOTHER'S MAIDEN NAME Katherine CHAMBERS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-079-841	17. INFORMANT CHART.		
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Arteriosclerosis Cardiovascular disease DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH years.
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sep. 16 1967 to Sep. 18 1967, that (I) (we) last saw the deceased alive on Sep. 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 9/18/67	
23C. PHYSICIAN'S NAME (Type) CESAR A. BRAVO				23D. ADDRESS BON SECOUR HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/20/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) BALTIMORE Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 20 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR E. S. Mac Nabb			
25D. ADDRESS 301 Frederick Rd. Balto 21228 Md					

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FUNERAL DIRECTOR: IMPORTANT

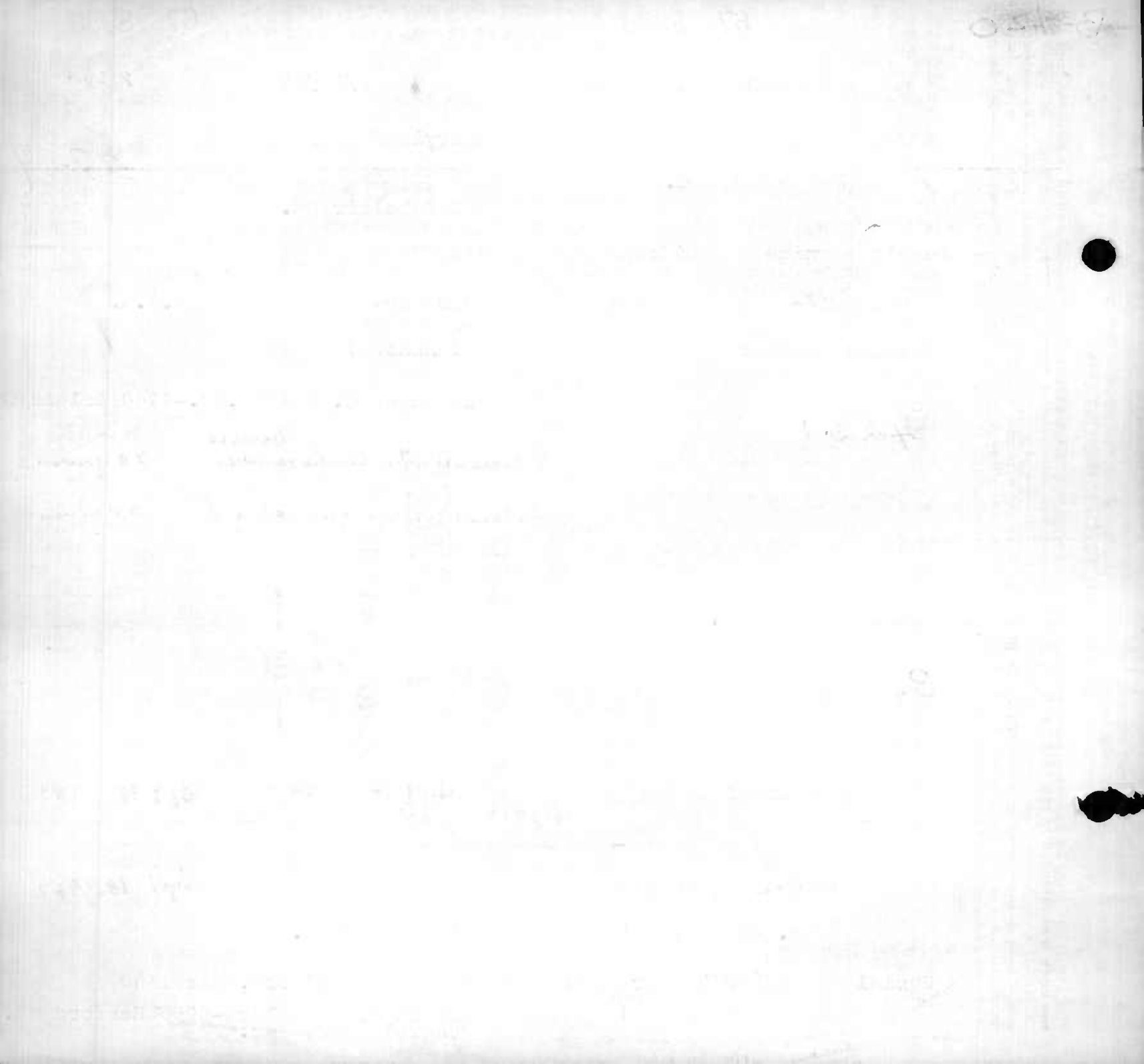
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 8998	
BIRTH NO. 67 8998				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Margaret Demby</i>			2. DATE AND HOUR OF DEATH <i>6 Sep 67</i> <i>8:30 A</i> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Fayette Convalescent Home</i> <i>1105 E. Fayette street</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-15</i> D. STREET ADDRESS (If rural, give location) <i>2101 W. Cold Spring Lane</i>		
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>12-6-1872</i>	9. AGE (In years last birthday) <i>94</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>DEM -</i>	11. BIRTHPLACE (State or foreign country) <i>222 Ford CO</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>George Demby</i>			14. MOTHER'S MAIDEN NAME <i>Brooks</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-32-2392A</i>	17. INFORMANT <i>Jo Ann Holly</i> ADDRESS <i>2411 Jersusalem Rd. Joppa Md.</i>		
18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <i>CHF (acute)</i> (B) DUE TO <i>Partial Heart Block</i> (C) <i>KEVD</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 d.</i> <i>1 mo +</i> <i>Indet.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11 Aug 1967</i> to <i>6 Sep 1967</i> . that (I) (we) lost saw the deceased alive on <i>6 Sep 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. Hulla</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6 Sep 67</i>
23C. PHYSICIAN'S NAME (Type) <i>J. Hulla</i>			23D. ADDRESS <i>2214 E. Fayette St Baltimore 21231</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-9-67</i>	24C. NAME OF CEMETERY or CREMATORY <i>Ebanesia Beth Choch Joppa</i>		24D. LOCATION (City, town, or county) (State) <i>Hanford Md</i>
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1967</i>		25B. NAME OF REGISTRAR <i>Paul E. Fackler</i>		25C. FUNERAL DIRECTOR <i>George W. Little</i> ADDRESS <i>BEL Air Md</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420		67 8999		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 8999	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) FREDERICKA W. BALIKO				2. DATE AND HOUR OF DEATH 9/16/67 8:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 6240 Belair Rd.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-34 D. STREET ADDRESS (If rural, give location) 6240 Belair Rd.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 8/1/79	9. AGE (in years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Buehler				14. MOTHER'S MAIDEN NAME (unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Alexander C. Baliko, Jr. - 6240 Belair RD			
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Anterosclerotic Cardiovascular Disease (B) DUE TO Anterosclerosis, generalized (C)		INTERVAL BETWEEN ONSET AND DEATH 20 years 20 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 15 1947 to Sept 16 1967 , that (I) (we) last saw the deceased alive on Sept 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Adam G. Swiss				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept 18, 1967	
23C. PHYSICIAN'S NAME (Type) Dr. Adam G. Swiss				23D. ADDRESS 6232 Belair Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/67		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1967		25B. NAME OF REGISTRAR Robert E. Tanenbaum		25C. FUNERAL DIRECTOR Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 9000		BALTIMORE DEPARTMENT OF HEALTH		Registered No. 67 9000	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>RANDALL, Norman JOSEPH</i>		2. DATE AND HOUR OF DEATH <i>9-18-67 5:40 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>UNIVERSITY of Maryland Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore City</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3323 W Belvedere Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9-4-99</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: Hours: Min. <i>0 14</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>House Painter</i>	11. BIRTHPLACE (State or foreign country) <i>BALTO MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>JOHN T RANDALL</i>			14. MOTHER'S MAIDEN NAME <i>FLORENCE RYDER</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes I</i>		16. SOCIAL SECURITY NO. <i>219-05-9492</i>	17. INFORMANT <i>GILBERT L. Randall 33 Wengate Rd Owings Mills</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>443X I</i>		CAUSE OF DEATH (A) <i>Acute Renal Failure</i> DUE TO (B) <i>Renal Nephrosclerosis</i> DUE TO (C) <i>Malignant hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Intracranial hemorrhage</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/9/67</i> 19 <i>67</i> to <i>9/18</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9/18</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Sandra Z. Salan</i>				23B. DATE SIGNED <i>9/18/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<i>Sandra Z. Salan MD</i>		<i>Univ. of Md. Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>	<i>9/21/67</i>	<i>BALTO NATIONAL</i>		<i>BALTO MD</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<i>SEP 20 1967</i>		<i>Gilbert L. Randall</i>		<i>8728 Liberty Rd Randalltown</i>	

James T. Randol
Francis K. Ryan
John T. Ryan
and Mrs. Robert L. Ryan
33 South 1st St.

James T. Randol
Francis K. Ryan
John T. Ryan
and Mrs. Robert L. Ryan
33 South 1st St.